APS TARC
Adult Protective Services Technical Assistance Resource Center

enhancing effectiveness of APS programs

BRIEF

# Behavioral Health and APS: The Overlooked Partnership

Summer, 2025

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# Background

## Introduction and Purpose

The relationship between adult protective services (APS) and behavioral health (BH) is important, yet poorly understood. It's important because maltreatment may contribute to BH conditions and BH conditions may contribute to maltreatment. It's poorly understood because few studies and no promising practices have been developed for maltreated adults with BH conditions. BH conditions experienced by APS clients or perpetrators may influence and complicate both investigation and intervention methods. Conversations with APS caseworkers reveal that cases involving BH conditions are often the most frustrating and challenging type of case. APS caseworkers are not mental health professionals nor substance abuse counselors, yet they may be expected to solve these types of problems.

Collaboration between BH services and APS is essential to ensuring the safety and well-being of vulnerable adults. Many individuals served by APS face complex challenges, including mental health conditions, substance use disorders, and cognitive impairments, which can significantly impact their ability to live safely and independently. BH professionals bring critical expertise in assessing and treating these conditions, while APS workers are skilled in identifying abuse, neglect, and exploitation. When these agencies work together, they can develop comprehensive care plans that address both immediate safety concerns and underlying BH needs. This integrated approach leads to more effective interventions, improves resource coordination, enhances decision-making, reduces the risk of repeated harm, and promotes long-term stability and quality of life for vulnerable adults.

## Definition

A BH condition is a mental health or substance use disorder that significantly affects a person's emotions, thinking, behavior, or overall functioning. These conditions result from a complex interaction of biological, psychological, social, and environmental factors and encompass a wide range of psychological and psychiatric disorders, including depression, anxiety, bipolar disorder, schizophrenia, post-traumatic stress disorder, eating disorders, and substance abuse or addiction. They are characterized by patterns of thoughts, feelings, or behaviors that cause distress or impairment in important areas of life, such as work, relationships, or daily activities. These conditions are treatable through various approaches including psychotherapy, medication, behavioral interventions, and supportive services.

## Overview

The purpose of this brief is to provide information to assist APS programs in achieving better outcomes for clients with BH conditions. It describes the scope of BH issues in APS and discusses ideas and resources for improving casework for this population. It is based on analysis of National Adult Maltreatment Reporting System (NAMRS) BH data, literature review, case studies on working with the BH system, and discussion of innovative BH projects with APS programs. Specifically, this brief provides

an overview of clients with BH issues in the APS system using NAMRS data, similarities and differences between the BH system and the APS system, followed by recommendations and resources for working with the BH system, including links to prior APS TARC products, identification of relevant National APS Training (NATC) courses, and discussion of case studies.

# Behavioral Health in the APS System

APS programs define eligibility for non-elderly adults based on "disability" or "vulnerability" due to a diagnosis or condition that, for many states, includes BH conditions. Research shows that in the general population, persons with BH conditions are much more likely to suffer from maltreatment. Schonfeld et al. (2006) found that, among Medicaid and Medicare clients, those with BH claims were much more likely to have been reported to an APS hotline. They also had costs ranging from 30% to 50% higher than other Medicaid and Medicare clients.

One in four older adults have a mental health condition and among adults age 50 and older, approximately 4.8% met criteria for alcohol use disorder and 1.2% for drug use disorder (National Survey, 2019). In the 2019 National Survey on Drug Use and Health (NSDUH, 2019), 1.5% of Americans age 50 and older (1.7 million) had any past-year mental illness and substance abuse disorder, and an estimated 0.5% (607,000) reported both a past-year serious mental illness and a past-year substance abuse disorder.

NAMRS asks about the BH condition of clients and thus provides information about the extent and nature of BH in the APS system. Federal fiscal year 2023 data indicates dementia, depression, and anxiety are the highest occurring BH conditions. The NAMRS definition for a BH condition requires it be based on the "results of clinical assessments on the client, conducted by the APS agency." Many states do not report this data element and, for the states that do report, the data in individual cases are often missing or reported as unknown. For federal fiscal year 2023, NAMRS data on BH is available from 21 states, but was reported for only 48% of clients across these states. This means that BH data from NAMRS is not nationally representative but does provide insight into the prevalence and nature of BH conditions among APS clients.

We examined the NAMRS data to determine for selected demographic and case characteristics what percentage of the clients and victims had a BH condition; the difference between clients who have BH conditions and those who do not; and the difference between clients and victims. The data show that at least 35% of APS clients have a BH condition. This percentage is even higher among younger clients (age 18-59); nearly half (46%) are identified as having a BH condition. There is no difference across sex. The percentage of clients with a BH condition varies across clients with different reported maltreatment types, but the percentage for whom BH condition is unknown also varies. The maltreatment types in which the highest percentage of clients had a BH condition were abandonment (62%) and sexual abuse

(56%). Clients experiencing self-neglect have the lowest percentage of identified BH conditions (28%) but also the highest unknown (60%).[1] We found that these patterns were similar for both clients and victims.

Across the 14 states that provided data on both BH condition and substitute decision-making, clients with BH conditions are much more likely (32%) than clients without BH conditions (17%) to have a substitute decision-maker at the start of an investigation, with financial and health care proxy significantly higher than other types (guardianship – non specified, of person, of property; representative payee). Finally, APS cases in which clients have BH conditions have longer case durations (60 days) than those in which clients do not have BH conditions (50 days).

While none of these findings are surprising, they affirm how important it is that APS staff understand the nature of BH conditions and how important it is to effectively work with the BH system. Appendix A provides a more detailed discussion of the BH data.

# Understanding the Behavioral Health System

The BH and APS systems have historically operated in separate spheres. Section 1324.403 of the APS Final Rule requires state APS programs develop standardized policies and procedures for consultation with "appropriate experts" and to "ensure coordination … with other appropriate entities." The preamble to the Final Rule cites BH as an area requiring expert consultation. The 2020 updated *National Voluntary Consensus Guidelines for State Adult Protective Services Systems* recommends that APS systems establish expert consultation to programs regarding mental health disorders, inclusion of mental health status and behavioral issues in needs and risk assessments, protocols to work in tandem with mental health clinicians and to offer mental health services, and core competency training and supervised fieldwork to include mental health disorders. As far back as 2009, research (Teaster, et al., 2009) pointed out, "A gap in knowledge exists, particularly on a systematic and empirical level, regarding how collaborative efforts have developed nationwide, how they function, and how many exist" (Teaster et al., 2009, p. 291). With exceptions discussed in the next section, this knowledge gap seems to remain today.

The term BH is often used interchangeably with mental health, even though there are separate systems of services for persons with mental health and substance abuse conditions. This section of the brief discusses APS relationship with each individually.

[1] One reason for this is the influence of Texas on self-neglect data. Texas has far more self-neglect cases than any other state and only submits yes or unknown. The Yes percentage increases 10% if you take Texas out.

## Mental Health System

There is a federally established and recognized system of services for mental health at the local level through community mental health centers (CMHCs). As formalized systems of services, APS and mental health have many common structures but important differences, often leading to frustration and conflicts. An APS caseworker or a mental health worker makes decisions based on structural aspects such as mission, policies and procedures (particularly), resources, and feedback loops. Understanding the similarities and differences in these structural elements, as shown in Exhibit A, will improve coordination of services.

APS plays a unique role in the social services delivery system. It is often called upon to support individuals whose needs are not fully met by other support systems, including BH. When someone's BH needs are not being met, it makes them more vulnerable and at risk of maltreatment. As discussed in the APS TARC webinar "Mental Health and Older Adults: What APS Needs to Know," APS generally does not diagnose mental health conditions, relying instead on mental health professionals and recognizing the unique needs of each client. Working with the population is further complicated by the stigma associated with mental health. Even though depression and anxiety are not normal signs of aging, individuals with these conditions are at greater risk of maltreatment and may be less willing to seek services. Interestingly, NAMRS data indicate that less than 2% of the known report sources for clients are BH providers.

The APS and mental health systems are similar in some terms of their philosophy, but overall mission and culture are different. The BH system emphasizes treatment while APS investigates. While values such as client autonomy and self-determination are important to both systems, the approach to services can differ due to their overall different purpose and goals. APS works to balance self-determination with client safety while the mental health system is more focused on treatment, recovery, therapy, and client empowerment. Some APS programs train their workers on a few therapeutic interventions, such as motivational interviewing, but therapy is not the primary focus of APS, and most APS professionals are not licensed or certified to provide mental health services. Instead, APS may help coordinate services and referrals — assuming the client with capacity accepts them — through other providers, including mental health services. CMHCs directly deliver a comprehensive array of services designed to support people with mental health conditions in their communities, emphasizing accessibility, continuity of care, and recovery-oriented approaches.

**Exhibit A. Comparison of Mental Health and APS Systems**

| Component | Mental Health System | APS System |
|---|---|---|
| **Authority** | Community Health Act of 1965 requires comprehensive community-based care regardless of age, including specialized services to older adults | No equivalent federal legislation establishing a system; APS Final Rule provides some system requirements |
| **Target Population** | Persons of all ages with serious mental illness | Vulnerable adults as defined by program policy; vulnerable often is defined, in part, by BH issues |
| **Administration/ Governance** | Community Mental Health Centers are typically nonprofit organizations reporting to the board responsible for oversight of the local system | Most APS programs are state or local government programs |
| **Mission** | Provide or arrange services for persons with mental illness | Investigate and address adult maltreatment (abuse, neglect, exploitation) |
| **Culture** | Emphasizes therapeutic relationships and recovery-oriented care, focused on long-term treatment | An investigative and protective framework focused on immediate safety and risk mitigation |
| **Philosophy** | Prioritizes client choice, self-determination, and confidentiality | Emphasizes client choice, self-determination, and confidentiality balanced against safety and risk mitigation |
| **Structure** | Medical model<br>Varies by jurisdiction<br>Local governance | Social work model<br>Varies by jurisdiction<br>State or local governance |
| **Assessment** | Multidisciplinary<br>May use team approach | Multidisciplinary<br>May use team approach |
| **Resources** | Mixture of public and private resources; funding levels require criteria for prioritization of persons served | Public resources that vary significantly from jurisdiction to jurisdiction; some programs fund services, others do not |
| **Services** | Provides biomedical and socioemotional intervention | Provides or arranges for wide range of social and health services |

*Source: Adapted in part from Teaster, et al., 2009.*

There is limited literature on the relationship between the APS and mental health system. Valerie Nash Chang and Roberta Greene (2001) reported on research into Indiana caseworker relationships with the CMHCs. The researchers found that "APS workers wanted more dialogue and better collaborative relationship between the two programs." Three problems were mentioned often. First, APS investigators had difficulty getting people evaluated and admitted to the stress unit or psychiatric unit because the client did not meet screening criteria of imminent danger and couldn't obtain the evaluation needed to determine if they met criteria. Second, the CMHC was hesitant to share information with APS investigators because it was considered confidential. Third, many CMHCs were not set up to do in-home evaluations for homebound APS clients. Potential solutions suggested were "… a memo of understanding that outlined roles and responsibilities of each program could lead to easier access to services and to a better understanding of appropriate referrals to go to the CMHC." The study recommended use of multi-disciplinary teams (MDTs), which have developed as service options since this research was conducted.

The only other study we found was by Teaster, et al., 2009, focused on understanding effective APS and mental health system collaborations. Similar to the previous study, they concluded that "Critical issues, such as parameters surrounding confidentiality requirements, criteria for addressing crisis situations, and resource limitations, may create friction between APS and mental health system professionals." The study found that most common working relationships were informal, with "cases gone wrong" often the reason for a collaborative relationship. Only one-fourth of respondents had a memorandum of understanding (MOU). Descriptions of the working relationship ranged from extremely positive to nonexistent. As in the study above, it was noted that APS requested in-home visits or assessments that the CMHC was not able to conduct. Differing definitions of emergency situations appeared to create strife in some collaborations, as do administrative priorities, treatment modalities, and acceptance of and attention to clients. Frustrations with efforts to work together were readily apparent. Conceptual misunderstandings about agency and program goals and methods and resource constraints seemed to underlie problems. The two factors most frequently cited as contributing to the success of APS and mental health system collaborations include cross-training and compatible individual working styles.

## Substance Abuse System

In contrast to mental health, there is no single recognized focal point at the community level for substance abuse services. Funding through the Substance Abuse Prevention and Treatment Block Grant, state appropriations, Medicaid, and criminal justice supports outpatient treatment programs, intensive outpatient programs, residential treatment facilities, detoxification centers, methadone clinics, and recovery support services. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides federal oversight and policy direction. SAMHSA promotes a model called SBIRT – which stands for screening, brief intervention, brief treatment, and referral to treatment – in primary care and community health settings, which is used in the ACL-funded opioid projects discussed in the next section. The SBIRT program integrates three core components: Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment; brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change; and referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

> The SBIRT model is used by health care providers and in schools (Substance Abuse and Mental Health Services Administration, 2024). The SBIRT model is universal and has been adopted for use by APS to identify substance misuse in older adults (see Appendix B for an excerpt on SBIRT model from the Opioids Pilot Project Implementation Guide). The SBIRT model involves screening, brief intervention, and referral to treatment. It engages with patients in a nonjudgmental and approachable way to develop a plan for reducing substance misuse. The SBIRT model is faster compared to traditional screening techniques and is used with all patients, regardless of their BH status, so it often results in early detection and intervention (Substance Abuse and Mental Health Services Administration, 2013).

The only research identified on substance abuse and APS was a study conducted for ACL (Teaster, et al., 2021). The purpose of this study was to understand the nature, extent, and challenges confronted by APS staff in providing services to clients affected by opioids. Based on phone interviews with field staff and analysis of NAMRS data for Missouri, the study examined scope and characteristics of caseloads, investigative methods, interventions, and services. It found that APS programs did not have specific policy or data on opioids. Cases involving opioids often concerned self-neglect, followed by caretaker neglect and facility drug diversion. APS staff stressed that available resources were inadequate for the complexities involved in working cases involving opioids and older adults, highlighting needs for greater financial assistance, enhanced and targeted training, specialists in addiction, and resources for homeless people. Working with community partners was a critical component to maximally helping older adults involved with opioid misuse. Appendix C provides the full list of findings.

# Resources for Working with the Behavioral Health System

This section summarizes work focused on improving the working relationship of APS and BH. To examine this work, we sent requests to the APS TARC listserv to identify BH-related projects but did not identify any significant projects other than the one discussed below. We also reviewed published literature; reviewed related ACL grant applications and reports; and reviewed past APS TARC products and NATC workshops (see Appendix D). This section highlights these projects with lessons learned for APS programs to improve services for clients with BH conditions.

## PROTECT Project

PROTECT, Providing Options to Elderly Clients Together, was a nine-week therapy developed in collaboration with partners at the Department for the Aging (DFTA) of New York City, integrated into elder abuse services to reduce depression and improve self-efficacy (satisfaction with services and problem-solving) among elder abuse victims. After a clinical evaluation, PROTECT was delivered in eight sessions to test the usefulness of adapted Problem-Solving Therapy (PST) and anxiety management. Of the 315 elder abuse victims screened over one year, 106 (34%) had clinically significant depression or anxiety and were recommended to receive a mental health treatment in conjunction with elder abuse services. (This was the highest rate of mental health needs reported by any aging service population in New York City.) Specifically, the PROTECT intervention "improved both mental health conditions and elder abuse self-efficacy services. Our findings demonstrate that the PROTECT intervention may alleviate older women's depressive symptoms and increase feelings of self-efficacy related to problem solving, both of which are critical to fostering resilience among victims" **(Sirey, et al., 2015).** Appendix E provides a more detailed summary of research results. In addition, the recently published research has found that PROTECT reduces suicidal ideation (Rollandi, et al., 2025) and PTSD (Culver, et al., 2025), regardless of client demographics or maltreatment type. The PROTECT Project also found, during COVID shutdown, that the video group completed therapy more quickly than the in-person group and had a more rapid improvement in depression symptoms (Rollandi, et al, manuscript), which is consistent with the findings in the previous APS TARC brief on forensic centers that remote assessments conducted by TEAM-FACN in Texas were successful.

New York City continues to operate the PROTECT project and it has recently expanded to Lifespan of Greater Rochester. In addition, Weill Cornell continues to research efficacy with a National Institute of Mental Health grant and is working with the National Adult Protective Services Association to administer a survey to find out what kinds of mental health resources APS programs use, barriers to their use, and obtain feedback on whether APS programs think the PROTECT model might be useful.

## Kansas APS CMHC Pilot Projects

Using federal funds, the Kansas APS program conducted a pilot project in collaboration with two rural CMHCs to address the behavioral health needs of APS clients. The project explored whether CMHCs could provide essential support services such as mental health assessments, medication compliance, social service connections, and case management for APS clients. The program was designed to test a "warm handoff" model, where APS professionals and mental health case managers jointly conducted initial client visits to ensure smooth engagement with services. One center succeeded by hiring a dedicated case manager who actively collaborated with APS and engaged in in-home visits, creating strong rapport and client participation. Staff enthusiasm, particularly from early adopters, was key in driving referrals and buy-in. Conversely, the second CMHC struggled with staff turnover and did not have consistent staff buy-in or case management, resulting in poor performance in meeting the project goals. The Kansas leadership team emphasized the importance of strategic management, including early staff engagement, leadership support, and clear communication of the case manager's role to clients. The project also highlighted systemic gaps in BH services for older adults and the need for more flexible and inclusive mental health funding. Despite uneven outcomes, the success at one CMHC led to a commitment to continue the program beyond ARPA funding, pointing to the potential for sustainable partnerships between APS and CMHCs if foundational elements — dedicated staffing, staff engagement, and clear processes — are in place. Kansas is still processing project data, and no formal evaluation of the project has been conducted.

## ACL Grant Projects

**University of Texas Health Sciences Center at Houston in Partnership with Texas APS Program**: In FFY 2022, ACL awarded an Elder Justice Innovation grant for stepped-care mental health screening and referral process for adults transitioning out of APS. The goal is to demonstrate the feasibility and effectiveness of a community-based stepped-care program to increase long-term meaningful social engagement and decrease depression and other negative psychosocial experiences of isolated APS clients. In this process, clients are screened through a tiered system for symptoms of trauma and mental health conditions, referred for full clinical assessments, and connected to trauma-informed care through UTHealth's Trauma and Resilience Center to improve their mental health as measured by improved depression scores, reductions in anxiety and stress, and increased emotional and informational support. An additional objective is to equip student volunteers who make social phone calls to isolated older adults with empathy-focused communication strategies and mental health awareness, particularly within the context of elder abuse, neglect, and exploitation. The intent of this training is to improve the quality and impact of the social phone calls as well as cultivate a future workforce more sensitive to the psychosocial needs of vulnerable older adults.

The preliminary analysis from the randomized control trial with 120 clients shows "positive trends in reducing loneliness and depression over the eight weeks in the intervention group, [but] the magnitude of the changes are small despite high enjoyment and expression of benefit from the older adults. The magnitude of change on the standardized measures are likely attenuated by several factors, but mostly

by the onset of new challenges that the older adult had to face, often alone. We learned that many of these individuals, despite receiving APS interventions, reported new social challenges that they were unable to navigate on their own. To effectively address the unmet psychosocial needs of the Texas APS population, there is an urgent need for a scalable, community-integrated intervention model. This model must be capable of systematically identifying and engaging socially isolated, lonely, and depressed older adults across the state; enhancing access to and utilization of evidence-based in-home depression treatments; and mitigating depressive symptoms along with concomitant psychosocial determinants" (Burnett, 2025).

**Elder Abuse Institute of Maine:** In FFY 2022, ACL awarded an Elder Justice Innovation grant to the Elder Abuse Institute of Maine for a two-year RISEUP project to integrate trauma-informed, restorative, and evidence-based practices for older adults affected by maltreatment and substance use. The project's central innovation lies in tailoring services to older adults by embedding mental health care directly within a broader system of elder advocacy and intervention, using a multi-disciplinary team that includes licensed clinical social workers, substance use disorder specialists, and restorative justice facilitators. A key component involves training and supporting Elder Advocates, who offer individualized, trauma-informed support and coordinate access to mental health and substance use treatment. RISESUP anticipates outcomes such as improved client stability, mental health, and engagement in services. It also seeks to improve data collection, protocol standardization, and systemic collaboration across protective services, justice systems, and behavioral health providers. At present, there has not been formal evaluation of the project.

**Opioid Research and Pilot Projects:** ACL established the APS Opioids Pilot Project to help APS programs better identify, assess, and support clients affected by substance use. The pilot has three goals: 1) identify and test effective, replicable strategies for serving APS clients with SUD; 2) support APS programs in implementing and evaluating those strategies; and 3) develop a replication guide based on pilot findings. The current pilot will evaluate the feasibility and effectiveness of SBIRT within APS settings by screening clients and perpetrators for substance use, providing brief interventions for those at moderate risk, and referring high-risk individuals to treatment. The pilot projects are in initial stages and no evaluation — which is built into the project — has yet been conducted.

# Discussion and Conclusion

Clients with BH conditions provide unique challenges for APS programs, not the least of which is working with a system of services that is often underfunded and has a different mission. The NAMRS data, research, and projects discussed above document the importance of the relationship between BH and APS systems. Only two-fifths of states collect data on BH conditions and, even if they do, often the BH condition of the client is not reported, limiting the understanding of the impact on APS programs. APS programs need to make a commitment to better understanding this important population through increased data collection.

There has not been much research and only a few grant projects focused on the partnership. Consequently, there are no best practices to highlight in this brief. To develop best practices, there is a need for a formalized evaluation and synthesis of findings from the BH projects discussed in this brief. By way of comparison, the RISE project, not discussed in this brief, has established a solid research base for the importance of partnerships in effective APS interventions. The related RISEUP project is collecting pre- and post-data on client quality of life in Maine for both RISE and RISESUP cases to compare their impact on client quality of life. Similarly, Kansas is still processing data from its pilot project, Weill Cornell is conducting additional research on PROTECT and the mental health needs of APS clients, and Texas has not published any research on its project. The ACL-funded APS Opioids Project plans to conduct a formalized evaluation, providing more insight on the SBIRT process and its relationship to APS. In a couple of years, once these projects have progressed and been evaluated, there should be a synthesis of results and ideally identification of best practices.

The research and evaluation of projects that have been conducted found that formalized relationships (such as MOUs) and constructive feedback loops are, not surprisingly, important for effective working relationships. The “one bad case” is not a good basis for policy or for a foundation for partnerships. Because the BH system is local, APS programs need to empower and make it a priority for local staff to establish effective working relationships with the BH system. The minimal research that has been done indicates that telemedicine approaches — as demonstrated in both PROTECT and TEAM-FACN in Texas — appear to be an effective tool in establishing delivering BH services. APS programs should use expanding availability of virtual services as an opportunity to increase client access to services.

Collaboration and cross-training are essential for building working relationships between the APS and BH systems. Collaboration encourages open communication, idea sharing, and joint problem-solving, which leads to more innovative solutions and stronger team cohesion. Cross-training complements this by equipping employees with a better understanding of the role, responsibilities, and limitations of the other program. Ongoing cross-training opens the discussion for APS and BH to share their program rules, responsibilities, and limitations for better understanding of what each program can and cannot do. While assuring compatible individual working styles can be difficult to manage, established MOUs can define the working relationships between the two program areas, including expectations around communication, roles and responsibilities, making referrals, and collaborating for the best client/patient outcome.

# Appendix A – Analysis of NAMRS Behavioral Health Data

As noted previously, NAMRS data on BH should not be viewed as representative of all APS programs across the nation. Nonetheless, the data provides insight into the nature and prevalence of BH in APS clients.

## Method

We analyzed NAMRS data for federal fiscal year 2023. NAMRS includes nine fields that identify individual clients as having specific BH conditions (alcohol use disorder, anxiety, bipolar disorder, dementia, schizophrenia or other psychotic disorder, traumatic brain injury, depression, substance use disorder, or unknown behavioral health condition). Of these conditions, dementia, depression, and anxiety are the highest occurring. The NAMRS definition for a client having a BH requires it be based on a clinical assessment, which an APS worker may not know or have access to. Further, many states do not require this information, so data for these elements are often missing or reported as unknown.

The following graphs show the percentage of clients identified with and without a BH condition for each data element. They also show the percentage for which BH condition is unknown[2]. We included data from 21 states that reported any clients with any of these BH conditions. Across all data elements, among the 302,581 clients in these states, BH status is unknown for 52%. Each graph shows the number of clients (n) for that data element and the number of states reporting the data element.

[2] The reader should not assume that the unknowns are distributed in the same ratio as the Yes and No responses. Review of state-specific data indicates that many states are mapping BH conditions either to Yes and No or Yes and Unknown, but are not differentiating between No and Unknown. Therefore, the Yes percentage should be considered the minimum percentage of clients, but it is not possible to estimate what percentage of the unknowns are actually Yes responses.

## Findings

We examined data both for victims and nonvictims, and did not find any notable difference in the patterns of BH conditions between them, so the following presents data on all clients (i.e., all individuals who were investigated by APS, regardless of the finding). Because of the high percentage of cases in which the BH condition is unknown or missing, the Yes responses below should be considered the minimum percentage.

As shown in Exhibit 1, 35% of APS clients have a BH condition.

**Exhibit 1. Percentage of APS Clients with Behavioral Health Conditions (n = 302,581 clients, 21 states)**

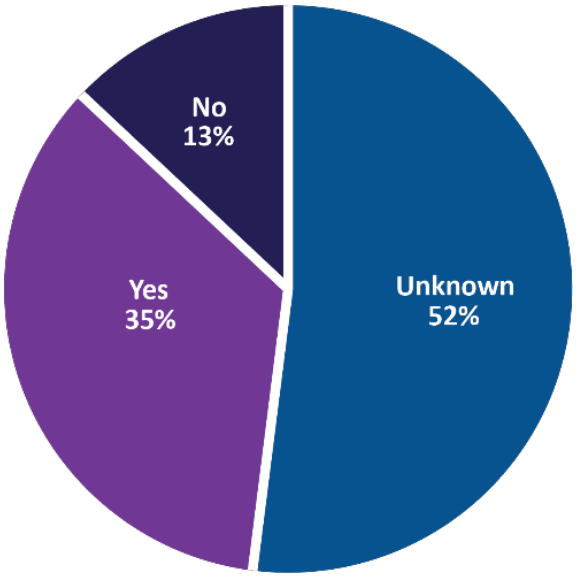
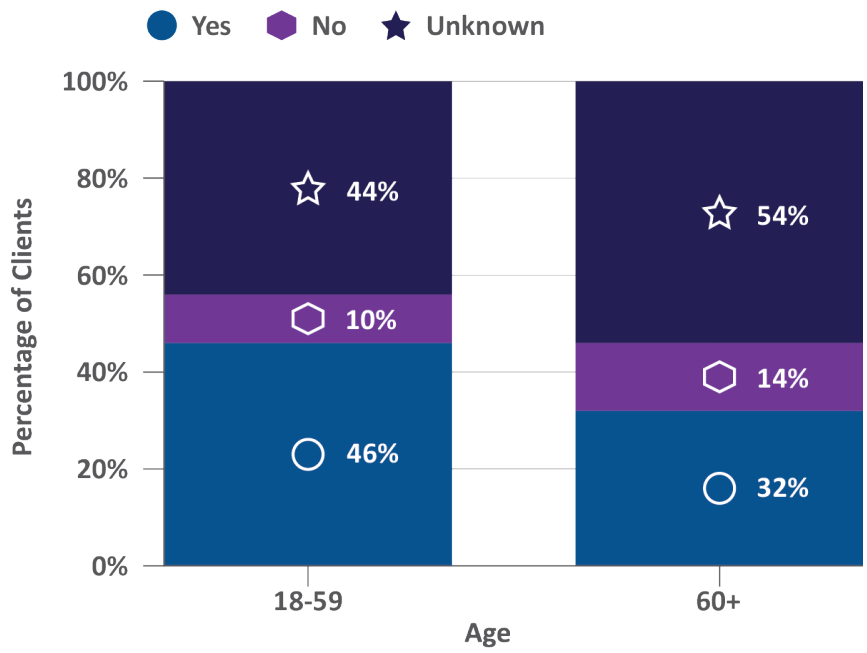


Exhibit 2 shows that younger APS clients are much more likely than older clients to have a known BH condition. Of those age 18-59, 46% were documented as having a BH condition compared with 32% of those 60 or older. APS programs require younger adults to have a disability or vulnerability to be eligible, so this difference is not surprising, and probably also accounts for why there is less unknown among the younger population.

**Exhibit 2 – Percentage of Clients with Behavioral Health Condition, by Age Group (n = 302,581 clients, 21 states)[3]**




[3] 5,722 of clients (n) had an unknown age and are not shown in the graph.

Exhibit 3 shows for each type of maltreatment the percentage of clients with a BH condition. Clients with abandonment and/or sexual abuse maltreatment are the highest at 62.2% and 56.0%, respectively. Self-neglect has the lowest percentage but also yields the greatest unknowns. This may reflect a range of factors including the lack of known support system, limited help seeking, or inability for the APS professional to gather information regarding client's diagnoses and conditions. It also reflects inclusion of Texas, which has a large number of self-neglect clients but poor BH data; exclusion of Texas would increase the Yes response for self-neglect to 38%.

**Exhibit 3 – Percentage of Clients with a Behavioral Health Condition, by Maltreatment Type (n = 302,581 clients, 21 states)**

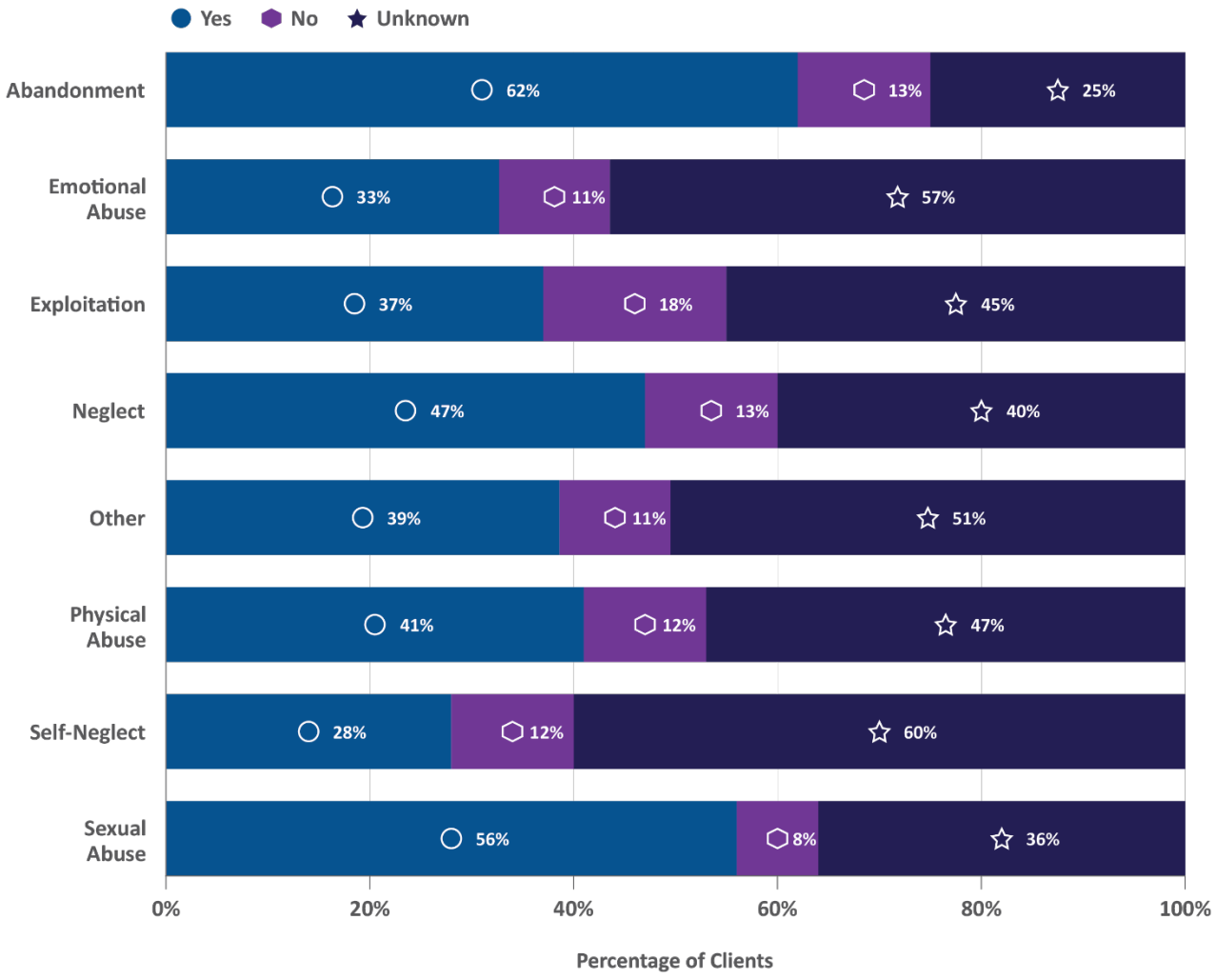
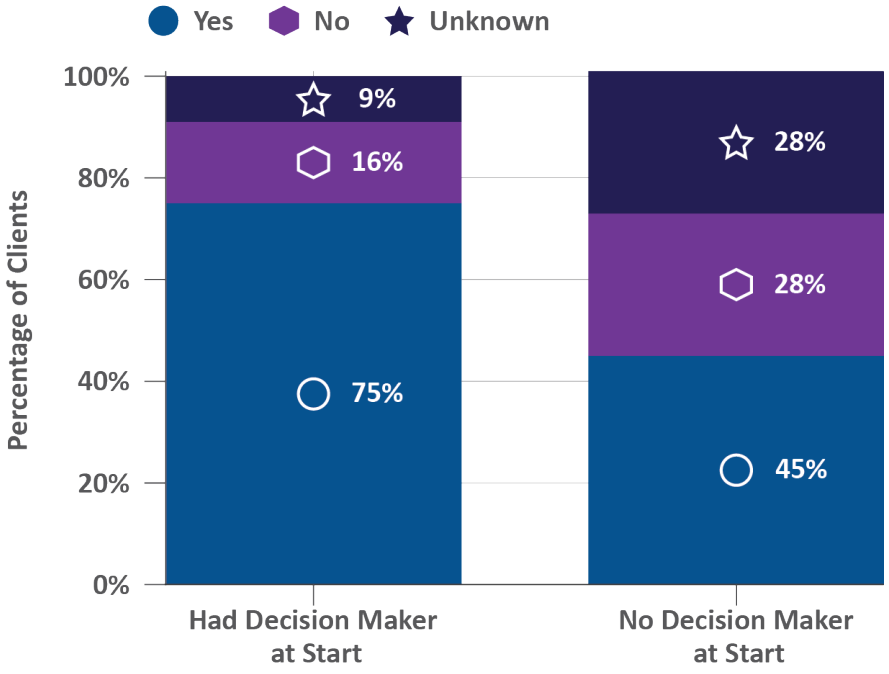


Exhibit 4 shows that clients with a substitute decision-maker at the start of an investigation are much more likely to have a BH condition. Of clients with a decision-maker, 75% had a BH condition compared with 45% of clients that did not have a decision-maker. If the decision-maker status was unknown, 68% of the clients had a BH condition.

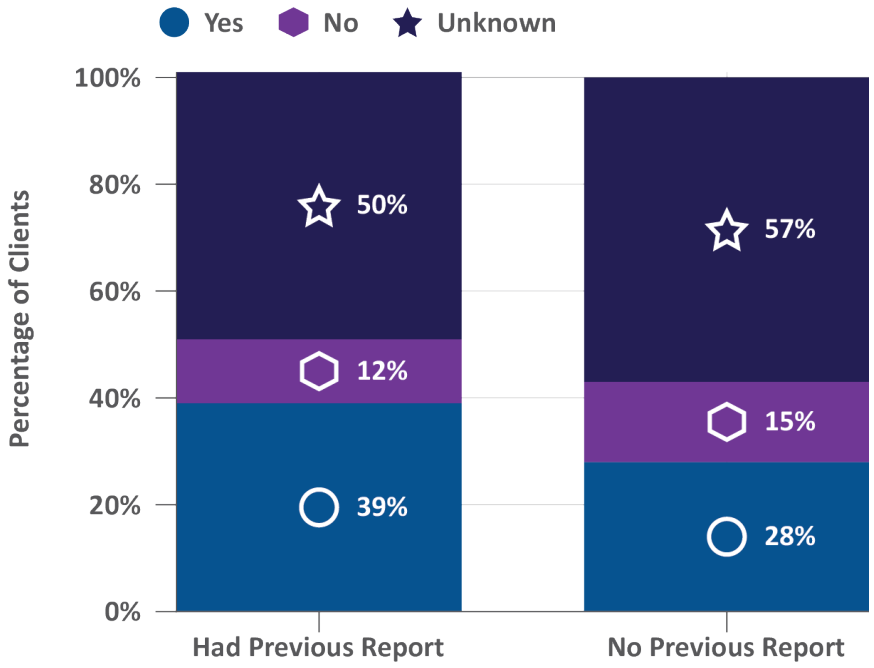
**Exhibit 4 – Percentage of Clients with Behavioral Health Condition by Substitute Decision-Maker at Start of Case Status (n = 134,179 clients, 14 states)[4]**




[4] For 23,379 clients, Substitute Decision-Maker at Start was unknown; these are not shown in the graph.

It appears that clients with a previous report are more likely to have a BH condition. As shown in Exhibit 5, for APS clients with a previous report, 39% had a BH condition and 12% did not. For those without a previous report, 28% had a BH condition and 15% did not.

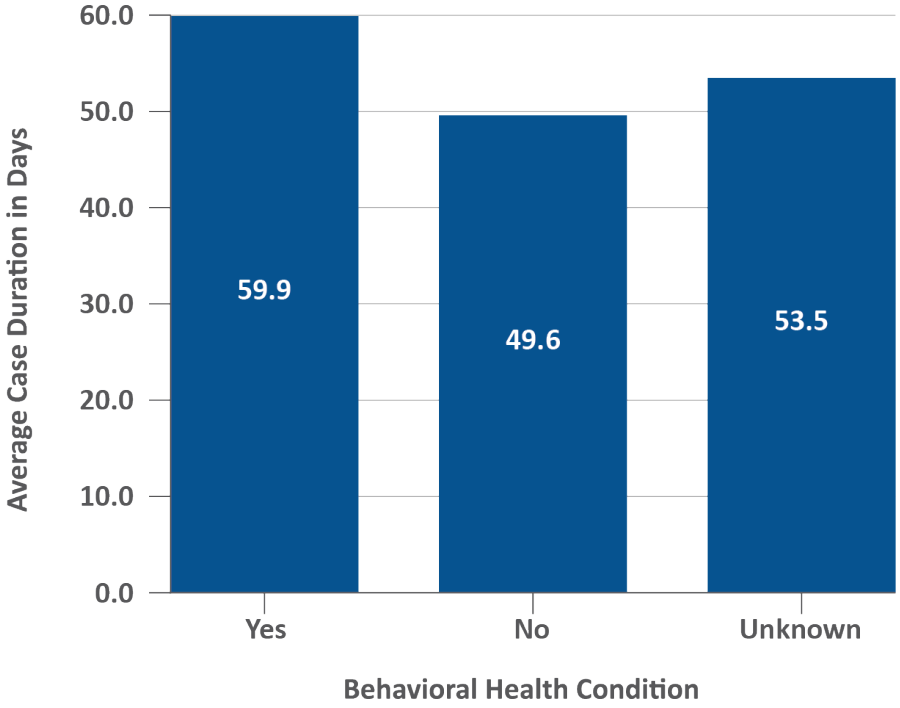
**Exhibit 5 – Percentage of Clients with a Previous Report by Behavioral Health Status (n = 283,729 clients, 16 states)[5]**




[5] For 41,697 clients, whether they had a previous report was unknown; these are not shown in the graph.

Exhibit 6 shows that the average case duration is longest for clients with a BH condition (n = 59.9 days). Case duration is fastest for clients without a BH condition (n = 49.6 days). This suggests that clients with a BH condition have longer case durations.

**Exhibit 6 – Average Case Duration for Clients by Behavioral Health Condition Status (n = 21 states)**



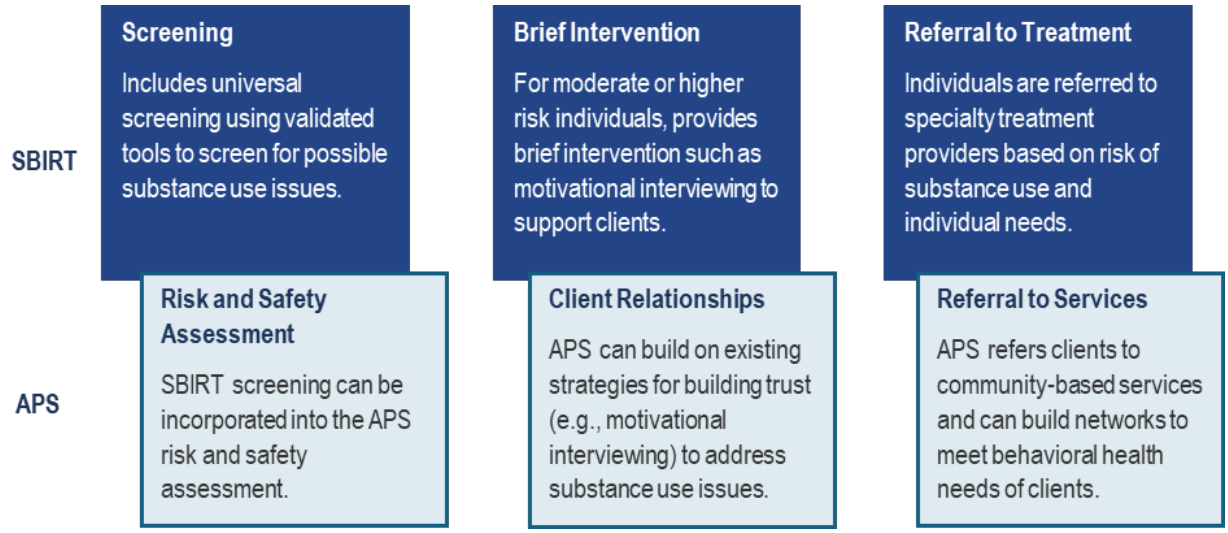
# Appendix B – Overview of SBIRT Taken from APS Opioid Implementation Guide (Excerpts)

SBIRT is the integration and coordination of screening and treatment components into a system of care that connects individuals with services that most closely align with their needs, which can range from prevention to specialty treatment. As the name indicates, the model consists of three key components: **screening, brief intervention, and referral to treatment.** SBIRT was originally developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) for use by primary care centers and hospital emergency rooms as a guide for quickly and comprehensively delivering intervention and treatment services for people with substance use disorders. Since its initial development, SBIRT has been shown effective in many alternative settings with a variety of populations, including vulnerable adults, and is relatively easy to learn and implement. The project team has adopted the SBIRT model for use with APS programs because of its natural alignment with APS processes and procedures and its potential to effectively improve the lives of APS clients.

SBIRT is an evidence-based approach found to be effective in addressing harmful drinking and alcohol use disorder in various health care settings for diverse patient populations including primary care, emergency departments, and schools and colleges. A growing body of investigator-initiated research and findings from SAMHSA-funded projects have shown promising results for the use of the comprehensive SBIRT approach, as well as selected use of individual components, in reducing risky drug use.

SBIRT not only encompasses promising and best practices from the SUD field, but it is also responsive to the realities of APS and addresses needs and challenges identified by APS administrators and caseworkers in supporting clients impacted by substance use. APS is well positioned to adapt SBIRT, or SBIRT components, by building on existing capacity and practices (see **Figure 1**). SBIRT includes universal screening to identify risk factors among clients and perpetrators, which can easily be incorporated into APS risk and safety assessment procedures. Brief intervention for clients and perpetrators at risk of substance misuse includes motivational interviewing – a skill that relies on trust between the APS caseworker and the individual – and is commonly used in APS to improve circumstances for APS clients. Referral to treatment closely aligns with APS' referral to community-based services when needed to address a client's safety risks.

**Figure 1. Alignment between SBIRT components and APS**




The SBIRT model adopted for this pilot project will have several additional benefits that reflect the context in which APS operates and addresses the challenges faced by APS in supporting clients impacted by substance use.

**SBIRT implementation requires a robust referral network**. APS programs expressed concern about the lack of community-based treatments available to support clients, highlighting that APS clients' vulnerabilities can add to the complexity of finding appropriate services in the community. This pilot will provide resources and support to APS programs to develop a referral network of local behavioral health providers and community-based organizations that can meet the needs of APS clients and perpetrators at high risk of substance use.

SBIRT is a promising approach for APS because **SBIRT services can be covered by several payers**. According to Section 1862(a)(1)(A) of the Social Security Act, Medicare and Medicaid cover reasonable and necessary SBIRT services in physicians' offices and outpatient hospital settings. SBIRT services are also covered by most commercial insurance plans. Another potential source of funding is Title III-D of the Older Americans Act, which supports education and implementation of evidence-based programs that promote healthful lifestyles and behaviors. Given that funding for SBIRT services is available, there may be potential for APS to partner with eligible entities and providers in the community to provide their clients with SBIRT services and make its use a sustainable practice.

**SBIRT will facilitate data collection and reporting on substance use.** APS administrators have indicated a lack of data on client and perpetrator misuse of substances, which can make it challenging to design, fund, and implement appropriate interventions. The pilot will prompt APS programs to document screening results, provision of brief intervention, and other factors to inform the pilot evaluation as well as future APS activities.

**SBIRT meets clients and perpetrators where they are**. Even when community-based behavioral health resources are available, APS may face client unwillingness or inability to accept help due to barriers like stigma, isolation, limitations in mobility, financial problems, and transportation issues. By training caseworkers to understand the impact of substance use and SUD, screen and assess risk, and provide a brief intervention, caseworkers will be better prepared to work with clients and perpetrators to identify and address barriers to treatment.

SBIRT provides caseworkers with a **systematic means for identifying and providing appropriate services** to individuals who clearly need but are not receiving treatment. SBIRT will also allow caseworkers to identify and intervene in substance misuse before an SUD develops. For APS, most clients and perpetrators may report minimal or moderate substance use issues and are likely not seeking treatment. Consequently, they may be an ideal group for harm reduction and universal prevention activities, such as those provided through the SBIRT model. Training in the SBIRT model will equip APS caseworkers with the skills to assess and engage those clients and perpetrators in a discussion about substance use, readiness to seek help, and treatment or service options.

**SBIRT will require limited additional time for most cases.** APS administrators and caseworkers highlighted that limited time with clients and perpetrators are barriers to addressing substance use during investigations. The project team selected SBIRT, in part, because of its flexibility and the limited time that will be required to screen most clients and perpetrators. The screening tool we selected for this pilot – the Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) tool – can be administered in as little as two minutes (for individuals who do not use substances) and up to 10 minutes (for individuals reporting problematic use). The pilot will also include a brief (three question) home assessment component to identify potential signs of substance misuse that are not reflected by individuals' responses to the TAPS screening.

The project anticipates that most APS clients and perpetrators will report no or low risk of substance misuse, so the brief intervention component will be administered to a small percentage of clients and perpetrators. When screening results indicate moderate or high risk, a caseworker will administer a brief intervention tool to encourage the individual to change their behavior and seek treatment if needed. Per the SBIRT model, treatment is provided by specialty providers. Thus, **the focus is on referring clients and perpetrators with need for treatment to appropriate treatment service providers.**

### A "brief" intervention

"When SBIRT is implemented properly, the time commitment is reasonable and acceptably low given the demonstrated success in identifying persons requiring referral to treatment." (SAMHSA, 2013).

**SBIRT is likely sustainable within APS beyond the pilot.**
SBIRT and accompanying motivational interviewing skills are easy to learn relative to other behavioral health techniques that may require lengthy specialized training. We anticipate that once new processes, caseworker trainings, and community-based resources are put in place through the pilot, this model will

be sustainable for APS with limited additional support. Because of SBIRT's wide use, researchers and experts have already developed **high-quality, free resources,** including screening tools, fact sheets or brochures, implementation guides, and trainings. For example, materials are available from SAMHSA's SBIRT grantees (https://www.samhsa.gov/sbirt/grantees).

# Appendix C – Findings from ACL APS Opioid Study

- No APS program we interviewed had a policy specific to older adults and opioids.
- Most APS administrators were unable to provide data-driven responses related to the number of APS reports in a year's time.
- When opioids were involved, allegations most often concerned self-neglect, followed by caretaker neglect and facility drug diversion.
- As with most types of elder abuse, perpetrators of opioid abuse were mostly family members, but at times facility staff were involved.
- A major challenge in working cases involving opioids was that the alleged perpetrator would also be present in the home as APS field staff attempted to interview the alleged victim. Other challenges included addressing the level of pain of the victim, and getting physicians to order lab work or having delays in lab work that would confirm the presence or absence of opioids in the bloodstream.
- The COVID-19 pandemic made it difficult for most field staff to investigate opioid-related cases.
- Most APS staff thought cases involving opioids were harder to substantiate due to the difficulty of proving if and how medication was missing and the denial of the victim if the perpetrator was a family member.
- APS staff identified long-term impacts that opioid misuse had on their clients, including inability to have their pain managed adequately, homelessness, poverty, and, in more than one case, a hastened death.
- Frequently suggested mechanisms for prevention were supportive formal and informal supports and services, particularly in medication management. The inability of the older adult to manage medications prescribed to them was the most common explanation for how older adults became victims of opioid abuse.
- Improvements to intervention for cases involving opioids included giving APS the ability to perform background checks, more frequent use of electronic medical boxes for appropriate and timely dispensing of medications, holding perpetrators accountable to timeframes, and policies to facilitate greater access and trust.
- Working with community partners was a critical component to maximally helping older adults involved with opioid misuse.
- APS staff stressed that available resources were inadequate for the complexities involved in working cases involving opioids and older adults, highlighting needs for greater financial assistance, enhanced and targeted training, specialists in addiction, and resources for homeless people.

# Appendix D – Available APS TARC Resources on Behavioral Health and APS

## Webinars

- Trauma Informed Supervision for Adult Protective Services
- Mental Health and Older Adults: What APS Needs to Know
- Grief, Depression, and Suicidality in Older Adults
- Understanding Decisional Capacities of Older Adults
- Scams and Fraud: Emotional Impact and Recovery
- Trauma Informed Care Approach to Elder Abuse

## Blogs

- Mental Health vs. Mental Illness: Distinguishing the Differences
- National APS Training Center (NATC) Courses
  - Case Collaboration in APS
  - Mental Health Issues
  - Motivational Interviewing
  - Substance Misuse and Substance Use

# Appendix E – Detailed Findings from the PROTECT Project

Compared to women in the referral group, those in the PROTECT intervention were significantly more likely to report having "most or all" of their needs met (78% vs. 35%) at the time of follow-up. Only a single victim in the PROTECT condition reported that "none" of her needs had been met; by contrast, over one-quarter (28%) of women who received only a referral (in addition to abuse resolution services) reported having none of their needs met. Those clients who stated that most or all of their needs had been met were also significantly more likely to report an improvement in abuse status. Nearly two-thirds (65%) of women in the PROTECT group indicated that they were "very satisfied" with the program, whereas only 35% of referral clients were satisfied overall with the services they received. Compared to victims in the referral condition, PROTECT clients were significantly more likely to report increased feelings of efficacy in dealing with their problems at follow-up. Most PROTECT clients (65%) indicated that the intervention had helped them "a great deal" with problem solving, compared to 43% of women who received a standard referral. Only two PROTECT clients (7%) reported that the intervention did not help "at all," whereas nearly half of referral clients (43%) said they did not feel any greater self-efficacy in dealing with their problems at follow-up. In addition, women who endorsed dealing more effectively with their problems were significantly more likely to report concurrent improvement in abuse status at follow-up.

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