Georgia Department of Audits and Accounts
Performance Audit Division
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Why we did this review

The Disabled Adults and Elder Persons Protection Act was established to protect mentally or physically disabled adults (18 years of age and older) and older persons (65 years of age and older) who are not residents of long-term care facilities from abuse, neglect, and exploitation. Research indicates approximately 10% of older adults will experience abuse, neglect, and exploitation and that not all instances are reported. We evaluated the extent to which: 1) mandatory reporters are reporting cases/allegations to Adult Protective Services (APS); 2) APS has sufficient resources to investigate reports of abuse, neglect, and exploitation; and 3) APS's interventions address elder abuse, neglect, and exploitation.

About APS

APS is administered by the Division of Aging Services (DAS) within the Department of Human Services. APS receives and investigates allegations of abuse, neglect, and exploitation of adults with disabilities and older adults. APS investigations have two purposes: to determine whether the allegations of abuse, neglect, and exploitation are true and identify any risks or unmet needs that a victim may possess and try to mitigate them. During fiscal year 2018, APS received 28,857 reports of abuse, neglect, and exploitation, accepted 21,526 for investigation, and completed 18,887 investigations. APS is funded primarily with state funds and has a budget of $18.6 million in fiscal year 2020.

Adult Protective Services

Action needed to improve awareness, intake, and victim follow up

What we found

While APS provides a necessary service, opportunities exist to improve protection of vulnerable adults. Abuse, neglect, and exploitation of vulnerable adults is underreported, limiting APS's ability to serve victims and prevent repeat occurrences. APS's intake and prioritization process requires improvement to ensure investigators' contact with victims is not delayed and that cases are not improperly rejected. Additional follow-up efforts are needed to ensure vulnerable adults receive services that could improve their situations and prevent repeat cases.

APS policies do not ensure that the most urgent reports of abuse, neglect or exploitation are addressed in a timely manner. The most urgent cases are those in which the victim lacks access to food, needs immediate medical attention, lacks needed supervision, has visible bruising, the alleged perpetrator has access to the victim, or sexual abuse is alleged. APS requires reports that have any of these risk factors be given priority status and that face-to-face visits occur within 2 business days. However, the time requirement begins only after APS has "accepted" a report, not when APS actually receives the report. The failure to account for the intake process time resulted in victims in at least 44% (or approximately 500 cases) of the priority cases accepted during fiscal year 2018 waited three or more calendar days to have face-to-face contact with an APS investigator. We found examples (approximately 108 cases in fiscal years 2016-2018) of priority case victims waiting 11 or more days for face-to-face meeting with APS.

In addition, APS is likely rejecting reports that should have been accepted for investigation and has miscategorized cases that require a priority response. Our review of intakes and the associated case file received in fiscal year 2018 identified instances

in which APS intake staff was inconsistently and potentially incorrectly determining whether and how a case should advance to investigators. Our review of intake records identified that of the 6,300 cases rejected in fiscal year 2018, 41% (2,600) had no documented reason in the case file. We reviewed 54 rejected cases[1] for which a reason was documented and identified 15 (28%) instances in which the information in the electronic case file contradicted the decision to reject. As a result, some victims of abuse, neglect, or exploitation may not have received an initial visit as quickly as the allegations warranted, while other potential victims may not have been served.

Case closure is based on completing the investigation and making referral to services, rather than services provided. As a result, victims may be left in the same situation or never receive the recommended services. This results in a higher risk for future occurrences, which means APS will receive another report to investigate.

APS investigators have limited access to informational tools that could enable them to efficiently conduct investigations. In addition, investigators do not have a central inventory system or other efficient means to identify service providers to meet victims' identified needs. As a result, investigators must conduct their own research, which may delay services to victims.

While APS and law enforcement each work with victims of abuse, neglect, or exploitation, there is limited communication and coordination among the entities. Without such coordination, victims of abuse, neglect, or exploitation incidents (which may also be criminal offenses) may not obtain the full scope of services available. Some law enforcement officials we surveyed and interviewed indicated that they were unfamiliar with APS and its responsibilities, as well as resources available to them to assist victims.

To support an increase in state-level law enforcement investigations of abuse, neglect, and exploitation, the General Assembly added $1.6 million to GBI's state appropriation in fiscal year 2016. The appropriations act stated the increase was to *increase funds for personnel for eight agents to specialize in elder abuse cases*. GBI did not utilize the increase in appropriations to add eight agents to specialize in elder abuse cases. Rather, GBI trained one agent in each of its 15 regions in elder abuse to act as a resource for other GBI agents. The estimated elder abuse workload for these agents equates to approximately two full-time employees. Because GBI does not track declined cases, the total number of elder abuse cases that GBI could investigate is not known.

What we recommend

APS should monitor the amount of time between report receipt and the face-to-face visit to ensure that abuse, neglect, or exploitation victims are being served in a timely manner. Also, APS should continue to monitor its intake process to ensure consistency in which reports are categorized and accepted for investigation. APS should consider instituting follow-up procedures with victims and service providers to facilitate service provision. APS should ensure investigators have sufficient information regarding victims' eligibility for APS services and other public benefits. APS should improve its outreach to mandated reporters.

The General Assembly should consider amending O.C.G.A. §30-5-4 to statutorily expand mandatory reporting requirements to state agencies that work with vulnerable adults or regulate the financial industry. Furthermore, the General Assembly should determine whether it should continue to fund eight GBI agents for elder abuse investigations

See Appendix A for a detailed listing of recommendations.

[1] The files for review were randomly selected and do not represent a statistically valid sample that can be extrapolated to the entire population.

DHS Response: *DHS generally agreed with the findings in the report. DHS also noted that "beginning in 2017, DHS has been proactively finding ways to continuously improve quality in its APS program." DHS noted that it has made enhancements to align with national standards set by the U.S. Administration for Community Living. These enhancements included policy revisions, training for new employees, specific training on capacity assessment tools, and improvements in call routing to reduce wait times for reporters. In addition , APS implemented enhancement recommendations from a review done by the National Adult Protective Services Association (NAPSA), including developing and executing a detailed training plan to achieve NAPSA certification for APS staff, expanding outreach and education to professionals on the role of APS and employing multi-disciplinary teams to collaboratively approach abuse, neglect and exploitation (ANE) of disabled adults and the elderly. Currently, 70 percent of APS staff have completed NAPSA certification training. Furthermore, DHS indicated that it is taking actions to implement multiple recommendations in the audit to continue its efforts to improve the APS program.*

GBI Response: *GBI contends that the model it used to support and train other agents about at-risk adult cases is a model that it has successfully used to address crimes against children. GBI indicated that to "only use numerical data to quantify the work special agents do and the impact they have on these cases in Georgia is risky."*

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Purpose of the Audit

This report examines the state's response to abuse, neglect, and exploitation of vulnerable adults, focusing on the operations of Adult Protective Services (APS). Specifically, the audit examines the extent to which

1. mandatory reporters are reporting,
2. APS has sufficient resources to investigate reports of abuse, neglect, and exploitation, and
3. APS's interventions address elder abuse, neglect, and exploitation.

A description of the objectives, scope, and methodology used in this review is included in Appendix B. A draft of the report was provided to the Department of Human Services (DHS) and the Georgia Bureau of Investigation (GBI) for review, and pertinent responses were incorporated into the report.

Background

Program Description

The Disabled Adults and Elder Persons Protection Act[2] was established to protect mentally or physically disabled adults (18 years of age and older) and elder persons (65 years of age and older) who are not residents of long-term care facilities from abuse, neglect, and exploitation.[3] The Department of Human Services' Adult Protective Services (APS) Program, within the DHS Division of Aging Services, receives and investigates reports of abuse, neglect, and exploitation, deters the ongoing maltreatment of persons with disabilities and older adults (vulnerable adults), and prevents its recurrence. O.C.G.A. §30-5-3 defines abuse, neglect, and exploitation as:

- **Abuse** - the willful infliction of physical pain, physical injury, sexual abuse, mental anguish, unreasonable confinement, or the willful deprivation of essential services to a disabled adult or elder person.
- **Neglect** - the absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a disabled adult or elder person.[4]
- **Exploitation** - the illegal or improper use of a disabled adult or elder person or that person's resources through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own or another's profit or advantage.

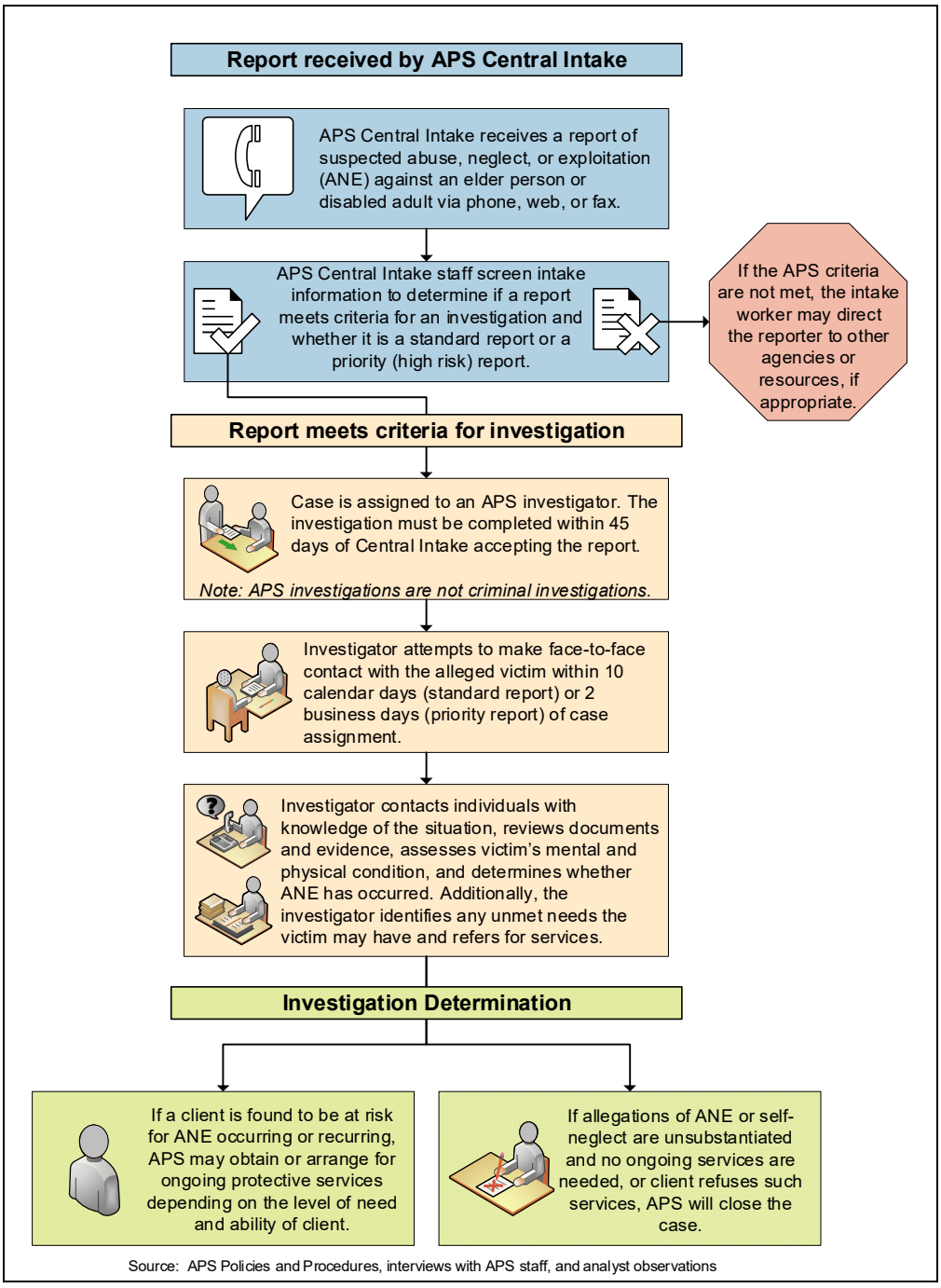
[2] O.C.G.A. §30-5-1 through O.C.G.A. §30-5- 11

[3] The Department of Community Health is responsible for oversight of long-term care facilities.

[4] APS also investigates self-neglect, although this is not a requirement under state law. Self-neglect occurs when a disabled or elder adult is unable to perform essential tasks of self-care due to a physical and/or mental impairment.

Exhibit 1 provides an overview of APS's process to receive, accept, and investigate reports of abuse, neglect, and exploitation. Once APS receives a report of abuse, neglect, or exploitation, the report is evaluated to determine if it will be accepted for investigation. If accepted, the case is assigned to an investigator who investigates the claims and determines the interventions that are necessary. While APS is responsible for investigating reports of abuse, neglect, and exploitation, the adult has the right to refuse to participate in the investigation or accept services.

Exhibit 1
Overview of the APS Process



Source: APS Policies and Procedures, interviews with APS staff, and analyst observations

Intake

O.C.G.A. §30-5-4 establishes requirements for reporting abuse, neglect, and exploitation to APS. The statute requires specific professions (mandated reporters) to report, but any individual who has knowledge of abuse, neglect, or exploitation may report. Mandated reporters are legally required to report abuse, neglect, and exploitation to APS and to an appropriate law enforcement agency or prosecuting attorney. In addition, O.C.G.A. §30-5-8 (A) (1) and (2) make it a misdemeanor for a mandated reporter to knowingly and willfully fail to report abuse, neglect, and exploitation of a disabled adult or elder person.

Reports of abuse, neglect, and exploitation are received by APS's Central Intake Unit. The Central Intake Unit is available to answer live calls from 8:00 a.m. through 5:00 p.m. Monday through Friday. If a call is received during those hours and no Central Intake Specialist is available, the live call is forwarded to the general DHS Call Center to be answered. Reports are accepted 24 hours per day by web or by fax. Central Intake has limited staff operating between 7:00 a.m. and 8:00 a.m. and from 5:00 p.m. to 7:00 p.m. Monday through Friday who can assist in reviewing any reports received.

Priority risk factors include circumstances in which the victim lacks access to food, has a need for immediate medical attention, lacks needed supervision, has visible bruising, the alleged perpetrator has access to the victim, or sexual abuse is alleged.

APS's Central Intake Specialists document the allegation(s) and determine whether the report meets the criteria for investigation. APS criteria require that the incident involve *a disabled adult or elder person who is harmed or threatened with harm either by the action or inaction of the adult or others.* If criteria are met, the case will be designated as a priority case or a standard case, depending on the risk factors identified by the Central Intake Specialist. Once criteria are met and case type is determined, the case is assigned to an APS investigator for investigation. Once assigned, the investigator must make contact with victims within 2 business days for priority cases and 10 calendar days for standard cases. If the APS criteria are not met, the intake worker will close the case and may direct the reporter to other agencies or resources, if appropriate.

In fiscal year 2018, APS received a total of 28,857 reports of abuse, neglect, and exploitation, of which 21,526 were accepted for investigation and 1,437 were assigned a priority designation.

Examples of Mandated Reporters for Abuse, Neglect, or Exploitation of Persons with Disabilities and Older Persons

- *Law enforcement personnel*
- *Hospital or Medical Personnel, Physicians, Licensed Nurses[1]*
- *Licensed Psychologists, Professional Counselor/Therapist, Social Workers*
- *Emergency Medical Technicians, Paramedics*
- *Disability Ombudsman*
- *Employees of financial institutions or investment firms[2]*

[1]Includes registered nurses, licensed practical nurses, and nurse's aides
[2]Only mandated to report financial exploitation
Source: O.C.G.A. §30-5-4; O.C.G.A. §37-2-36

Investigation

APS investigations have two purposes: to determine whether the allegations of abuse, neglect, and exploitation are true and identify any risks or unmet needs that a victim may possess and try to mitigate them. APS investigations are not criminal investigations, and APS investigators do not bring criminal charges. If criminal activity is identified, APS investigators notify law enforcement and law enforcement determines whether criminal charges should be filed. In some instances both APS and local law enforcement may investigate the same allegation, but the investigations have different purposes. The APS investigation is to mitigate the risk of further harm and meet the needs of the victim. The law enforcement investigation is to determine if criminal acts occurred.

During the investigation, the APS investigator meets with the victim and others with knowledge of the situation (including the alleged perpetrator), reviews any available information that demonstrates abuse, neglect, or exploitation (e.g., bruises/marks on the victim, physical condition of the victim, financial documents, etc.), and determines whether the alleged act of abuse, neglect, and exploitation occurred. In addition, the investigator also conducts assessments of the victim's ability to perform basic activities of daily living,[5] the living environment, and capacity to make and understand decisions. According to APS policy, the investigation and assessment should be completed within 45 calendar days. The potential outcomes, or disposition of an investigation are that the allegations[6] are substantiated, unsubstantiated, or inconclusive.[7]

During fiscal year 2018, APS completed 18,887 investigations, resulting in 7,542 cases where it was determined that abuse, neglect, or exploitation occurred. Of the 7,542 cases, 5,081 (67%) were abuse, neglect, or exploitation because of the actions of another person and 2,461 (33%) of the cases were self-neglect. According to APS policy, substantiated cases of abuse, neglect, or exploitation are reported (except for cases of self-neglect) to local law enforcement via a written report. Local law enforcement may take action as they deem appropriate or may view the reports as informational.

Examples of services that APS may assist a victim with obtaining include respite care, mental health counseling, personal care home placement, financial management, transportation, and Meals on Wheels.

Assistance may be offered to the victim; however, outside of limited emergency situations, APS refers but does not pay for services during the investigation. In general, victim resources are used to pay for services, such as doctor visits or home health. As a part of case management, an APS investigator will assist victims with accessing public benefits or finding non-profit entities to provide the services. APS investigators primarily use the Aging and Disability Resource Connection (ADRC) within the Area Agency on Aging (AAA's) but will also use nonprofits, such as foodbanks or churches to provide services. If a service is offered through an AAA, but no space is available, the victim may be added to the waiting list. A victim does not move ahead of others on

[5] Eating, walking, bathing, dressing, etc.

[6] One investigation may include multiple allegations, such as physical abuse and financial exploitation. Allegations include self-neglect as well as abuse, neglect, or exploitation committed at the hands of another person.

[7] Used when the victim, others with knowledge of the situation, or supporting information was unavailable or insufficient.

the waiting lists by virtue of being an APS client. Victims have the right to refuse services at any time.

APS may continue to monitor a victim to reduce the risk of further abuse, neglect, or exploitation occurring. Continued monitoring, referred to by APS as "ongoing services," is provided based on the type of abuse, the victim's situation, and the level of need and ability. Investigators are required to conduct at a minimum one face-to-face contact with the ongoing protective services victim every month. Approximately 500 cases received ongoing services at some point during fiscal year 2018.

In addition to APS's involvement with abuse, neglect, or exploitation of persons with disabilities or older adults, local law enforcement and GBI conduct criminal investigations of abuse, neglect, or exploitation of persons with disabilities and older adults. These are in addition to APS's investigations. O.C.G.A. §16-5-101 (d) makes neglecting a disabled adult or elder person a felony with a penalty of from one to twenty years in prison, a fine of $50,000 or less, or both imprisonment and a fine. O.C.G.A §16-5-102 (a) says that the exploitation, abuse, or willfully depriving essential services of a disabled adult or elder person has a penalty of from one to twenty years in prison, a fine of $50,000 or less, or both imprisonment and a fine, and is a felony.

Organization and Staffing

As shown in **Exhibit 2**, the APS Program consists of three districts and 12 regions that mirror the DHS Planning and Service Areas.

Exhibit 2
APS Districts and Regions as of June 2019

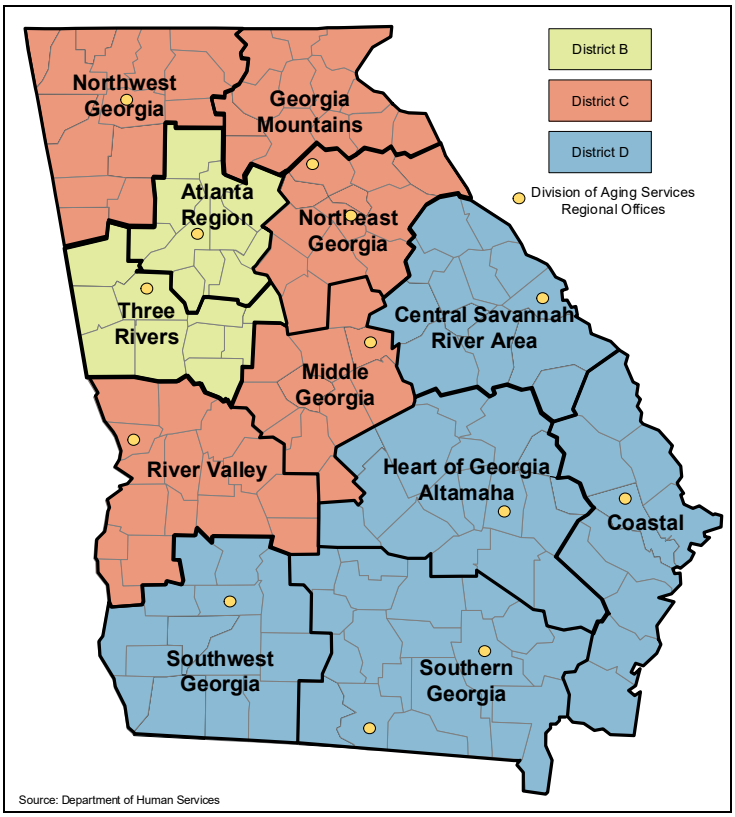
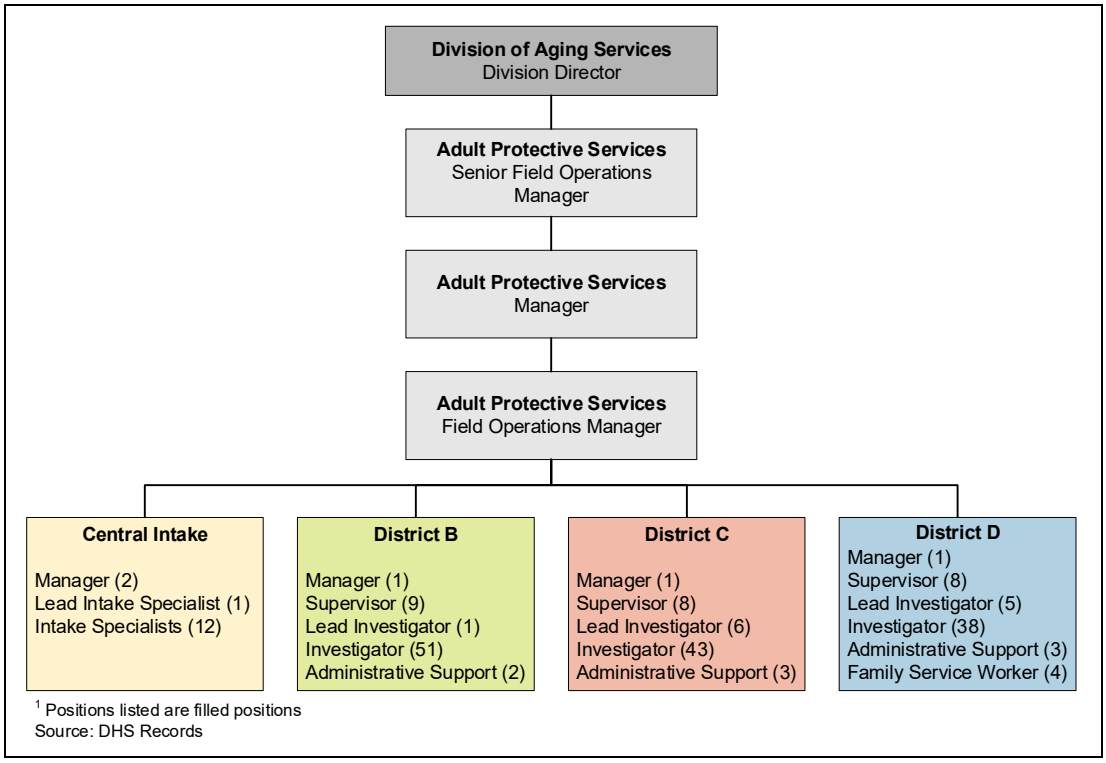


Exhibit 3 is the organizational chart for APS. Staff are assigned to DHS's offices in Atlanta or one of the 12 Regional DAS offices. APS has 203 employees.

Exhibit 3
Organizational Chart of Adult Protective Services, as of May 2019[1]



[1] Positions listed are filled positions
Source: DHS Records

Financial Information

As shown in **Exhibit 4**, in fiscal year 2020, APS was budgeted to receive state appropriations of approximately $16.6 million and $2 million in Social Services Block Grant (SSBG) funds, for total funding of $18.6 million. SSBG funds are federal funds that are awarded to states based on population that are to be used to fund activities that serve vulnerable populations. In its fiscal year 2020 state appropriation, APS received funding for an additional 17 adult protective services positions.

In addition to its operating funds, APS has access to emergency funds not included in its budget to assist victims who lack resources to meet their needs in certain circumstances. These funds are Emergency Relocation Funds (ERF) and Temporary Emergency Relocation Funds (TERF). ERF can be used to address a multitude of victim needs including but not limited to food, pest control, home repairs, clothing, furniture, and medication. TERF is used to serve victims identified by law enforcement officers, Department of Community Health's Healthcare Facilities Regulation staff, or Adult Protective Services investigators that find a vulnerable adult in need of emergency housing for a short period of time (from 1 to 7 days). In fiscal year 2019, a total of $477,578 was expended and in fiscal year 2020, $626,800 was budgeted

for TERF and ERF. TERF and ERF are state funds and unspent funds lapse at the end of the fiscal year.

Exhibit 4
APS Fund Sources and Expenditures, Fiscal Years 2019 and 2020

	2019	2020 (Budget as of August 2019)
Fund Sources		
State Appropriations	$15,126,068	$16,637,282
Social Services Block Grant	$1,279,491	$1,972,281
Total	$16,405,559	$18,609,563
Expenditures		
Personal Services	$12,762,716	$14,319,435
Regular Operating	$1,317,188	$1,940,664
Computer Charges	$139,931	$82,625
Real Estate	$327,264	$421,779
Telecommunications	$1,051,956	$1,004,050
Contracts	$504,739	$547,070
Grants and Benefits	$242	$ - - -
Other	$301,524	$293,940
Total	$16,405,559	$18,609,563

Source: Fiscal Year 2019 and 2020 TeamWorks Budget Comparison Reports

Findings and Recommendations

Finding 1: Abuse, neglect, and exploitation of vulnerable adults is underreported, limiting APS's ability to serve victims and prevent future occurrences.

APS does not receive reports of all abuse, neglect, or exploitation occurrences. This includes underreporting by mandated reporters and other persons or entities that would have knowledge of such instances. Multiple law enforcement personnel we interviewed indicated they do not report all cases of abuse, neglect, or exploitation to APS. In addition, almost half (67 of 141) of law enforcement survey respondents and more than half (14 of 25) of district attorney survey respondents were somewhat, slightly, or not at all familiar with APS activities. APS relies on reports to coordinate services and identify the extent of abuse, neglect, and exploitation in Georgia. If reports are not made, victims cannot obtain potentially necessary services and may be at continued risk for future occurrences of abuse, neglect, or exploitation.

Research indicates that approximately 10% of older people will likely become victims of abuse, neglect, and exploitation and that incidents are underreported to authorities. In addition to the specific examples of non-reporting as discussed within this finding, the variation in reporting among counties with similar vulnerable adult populations also suggests potential underreporting. While some variation would be expected, the magnitude of the variation may indicate that cases were not reported. For example, as shown in **Exhibit 5**, Toombs and Oconee counties have similar populations, but more than twice as many abuse, neglect, or exploitation reports were taken from Toombs. Similarly, Cobb and Gwinnett counties have a comparable vulnerable adult population, but Cobb submitted approximately 50% more reports than Gwinnett.

Exhibit 5
Abuse, Neglect, and Exploitation Reporting Varies Among Counties with Similar Vulnerable Adult Populations (FY18)

County	Vulnerable Adult Population	Total Reports
Toombs	6,211	78
Oconee	6,695	35
Houston	27,681	349
Columbia	26,042	222
Cobb	113,087	1422
Gwinnett	113,555	927

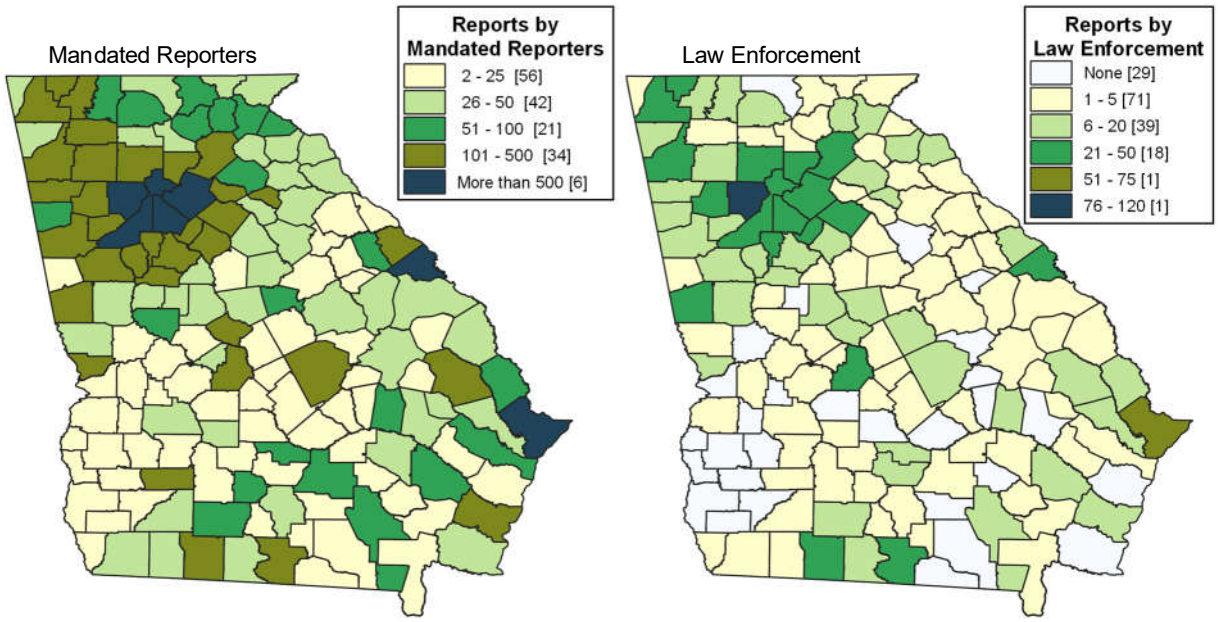
Source: Audit team analysis of APS data and Census Data

Abuse, neglect, or exploitation is underreported among mandated reporters. Our analysis of reporting by mandated reporters identified significant variations in counties with similar vulnerable adult populations. For example, law enforcement in Cobb reported more than five times as many incidents as law enforcement in Gwinnett, while licensed nurses[8] reported two times the number of incidents. As

[8] Includes Registered Nurses, Licensed Practical Nurses, and nurse's aides.

shown in **Exhibit 6**, 98 counties had 50 or fewer reports from mandatory reporters in fiscal year 2018. These 98 counties have a vulnerable adult population of approximately 318,900; the 2,300 reports from these counties represented a rate of less than 1%. Among law enforcement (which are often first responders to abuse, neglect, or exploitation occurrences), 29 counties had no reports, and another 24 had one report. See the information box on page 10 for a discussion of law enforcement reporting.

Exhibit 6
Reports by All Mandated Reporters and Specifically By Law Enforcement, FY2018



Source: DOAA analysis of APS Data

Law Enforcement Abuse, Neglect, or Exploitation Reporting

Despite their statutory requirement to report abuse, neglect, or exploitation, law enforcement officials appear to exercise discretion when deciding whether to report to APS. Our visits with law enforcement agencies identified that officers are hesitant to report cases that involve certain types of victims or abuse. Reasons law enforcement gave for not reporting some cases include: not believing that the victim needs services; not considering financial scams to be financial exploitation; and not wanting victims to infer that they are viewed as no longer being able to care for themselves. Additionally, some law enforcement officials indicated they prefer to handle the situation themselves because of a negative experience with APS, or they believe that APS is over-worked and cannot handle all of the cases reported.

During the audit, news reports highlighted several cases involving physical abuse of older adults or adults with disabilities. Though these cases included a law enforcement response, they were not reported to APS. For one case involving an individual already in the APS case management system, the audit team contacted one of the four the law enforcement agencies involved to inquire whether an APS report would be made. The representative indicated that law enforcement should be able to use their judgment regarding whether to report and that this victim did not need APS services. Subsequently, however, law enforcement made an APS report.

In reviewing this case, the audit team identified that this victim was treated at an emergency room and that hospital personnel, who are also mandated reporters, did not make an APS report.

As previously mentioned, if incidents are not reported to APS, victims may not receive social services such as meals on wheels, home health, or homemaker services, which law enforcement generally does not obtain for victims.

Abuse, neglect, or exploitation is also likely underreported because certain state entities that may have knowledge of instances are not required to report in statute. As described below, these entities serve adults with disabilities directly or regulate aspects of the financial industry in Georgia.

- The Georgia Vocational Rehabilitation Agency (GVRA) serves approximately 35,000 adults with disabilities; however, it generally does not report abuse, neglect, or exploitation to APS. From fiscal year 2015 to 2018, vocational rehabilitation counselors made eight reports. While GVRA's general counsel stated that vocational rehabilitation counselors are not mandated reporters, the DHS Associate General Counsel for the Division of Aging Services was unsure if GVRA counselors are considered part of the requirement.[9]

- Although O.C.G.A §30-5-4 requires financial institutions to report, state institutions that regulate the financial industry are not mandated reporters. For example, the Secretary of State's Securities & Charities Division's employees may identify victims of financial exploitation through complaints

[9] In its list of mandated reporters, state law includes "professional counselors licensed pursuant to Chapter 10A of Title 43", which includes counselors who assist people in identifying and resolving vocational concerns; administer and interpret vocational assessment instruments, utilize functional assessment and vocational planning and guidance for persons requesting assistance in adjustment to a disability or disabling condition. This may include GVRA counselors.

and investigations related to securities fraud or fake charities. Likewise, the Department of Banking and Finance may receive complaints that involve predatory lending practices involving vulnerable adults. Finally, the Department of Insurance regulates annuities, which are commonly prone to unfair sales practices, and may identify cases involving vulnerable adults. It should be noted that certain employees of the Department of Insurance Fraud Unit are mandated reporters because they are law enforcement personnel; however, they were not aware of their responsibility to report until the audit team spoke with them.

While APS's policy states that APS is responsible for coordinating with other agencies and conducting public awareness activities on the issues of disabled adult and elder abuse, APS does not have a formal plan for outreach and marketing. Rather, APS staff stated they only give presentations and training upon request. This contributes to the lack of familiarity with APS.

RECOMMENDATIONS

1. APS should improve its outreach to law enforcement specifically and other mandated reporters to ensure that they are aware of their legal responsibility to report.
2. APS should periodically analyze reporter data to identify types of reporters or areas of the state to target outreach efforts. For example, if APS identifies underreporting by a specific type of mandated reporter, they could reach out to governing boards or professional organizations (e.g., Board of Nursing, Sheriffs' Association) to further educate members regarding the statutory requirement.
3. The General Assembly should consider expanding O.C.G.A. §30-5-4 to statutorily require agencies that work with vulnerable adults or regulate the financial industry to report relevant occurrences to APS.

DHS Response: *DHS agreed with the finding and indicated that it has started taking action to address the recommendations. DHS indicated that "the DHS Forensic Special Initiatives Unit (FSIU) has expanded outreach to law enforcement and other mandated reporters through At-Risk Adult Crime Tactics (ACT) training." DHS has also improved its outreach efforts to mandated reporters by updating APS educational materials and using them to educate community stakeholders on reporting abuse, neglect, and exploitation and the role and limitations of APS. Additionally, DHS indicated that it will review reporter data quarterly to identify underreporting by specific mandated reporters to target further outreach efforts. Finally, DHS noted that in 2019 it proposed legislation to amend O.C.G.A. § 30-5-4 to expand the reporting mandate on banks/financial institutions to include reporting of abuse and neglect; however, DHS indicated that the proposal faced opposition from representatives of the banking and finance industry due to concerns related to banking regulations and monitoring.*

Finding 2: APS's policies related to intake may result in investigators' delayed contact with victims.

APS policies and business processes do not consider the amount of time from receipt of a report to a report being "accepted" in determining the amount of time a victim may have to wait to receive a visit from an investigator. This time lag may unnecessarily put victims of abuse, neglect, or exploitation at risk for continued harm. This is concerning for priority cases, where an increasing number of victims wait more than three calendar days for contact with an APS investigator.

In an effort to prioritize investigators' workload, APS policies categorize cases based on their risk factors and assign different time requirements for meeting with the victim. These risk factors include circumstances in which the victim lacks access to food, has a need for immediate medical attention, lacks needed supervision, has visible bruising, the alleged perpetrator has access to the victim, or sexual abuse is alleged. Reports that contain any of these risk factors are given priority status that should result in a shorter timeline to meet with the victim. Standard reports require an initial face-to-face visit within 10 calendar days while priority reports require a face-to-face visit within 2 business days. However, the time requirement begins only after APS has "accepted" a report, not when APS actually receives the report.

APS policies do not sufficiently address the full timeline from report submission to a face-to-face meeting with the victim. Specifically, there are no codified requirements for Central Intake to accept or reject a report for further investigation within a certain amount of time.[10] Rather, time requirements (and APS monitoring) begin only after Central Intake has accepted the report. Additionally, APS's policy for face-to-face meeting with priority cases is based on business days rather than calendar days, which further delays contact with the victim. For example, as demonstrated in **Exhibit 7** below, APS policy requirements were met in a fiscal year 2018 case involving physical abuse, though the victim waited more than a week to see an APS investigator.

Exhibit 7
Timeline for a Fiscal Year 2018 Priority Intake - Actual Web Report - Meets APS Policy Requirements

Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
1	2	3	4	5	6	7
Reporter Makes Report by Web						
8	9	10	11			
1. Central Intake Reviews and Accepts Report 2. APS Starts Tracking Intake/ Time			**Investigator Visits Victim** A Visit within 2 Business Days Meets APS Policy			

Source: DOAA analysis of APS Intake

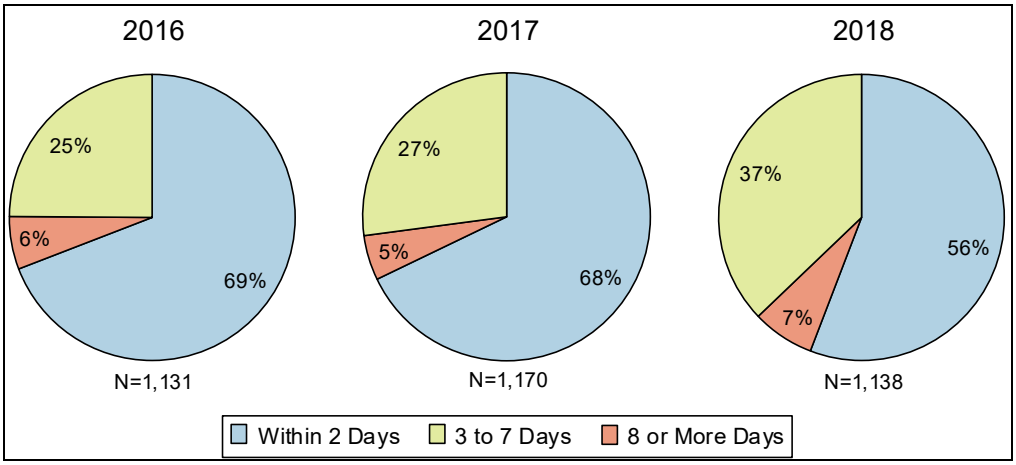
[10] APS staff noted that an internal process instructs intake staff to mark reports as incomplete and close the intake file after two days when information is missing; however, there are no other time requirements for Central Intake review.

The length of time it takes for Central Intake to review a report after it is submitted contributes to the delays in meeting with the victims. In approximately a quarter of the cases that took three days or more, the longest portion of wait time was between report receipt and Central Intake review.

Because Central Intake only accepts live calls from 8 a.m. to 5 p.m. Monday to Friday, delays are particularly prominent for reports that are submitted at night and on the weekends. These reports (which are submitted through the website) represented an increasing proportion of total priority reports, and in fiscal year 2018, nearly half were not reviewed within 24 hours. By contrast, nearly all reports directly taken by Central Intake[11] were reviewed within one day.

As shown in **Exhibit 8**, while victims in approximately 65% of the priority cases accepted over the past three fiscal years had face-to-face contact within 2 calendar days, victims in at least 35% of the priority cases waited three or more calendar days to have face-to-face contact with an APS investigator. The percentage has increased over time, with approximately 44% of priority case victims waiting three or more days in fiscal year 2018, compared to 31% in fiscal year 2016. During fiscal years 2016 through 2018, victims in 214 priority cases did not see an investigator for more than a week after the incident was reported to APS. Our review indicated that 68% (839 of the 1,229) cases that took three or more days for an investigator to visit a victim were submitted through the website or the DHS Call Center.

Exhibit 8
The percentage of Priority Cases taking 3 or more calendar days for a visit by an investigator is increasing[1]



[1] Numbers rounded to equal 100%
Source: DOAA analysis of APS Intake data

Best practices[12] recommend that adult protective services programs have a process by which reports are reviewed and assigned for investigation, referred to other providers,

[11] These reporting methods include phone calls answered by Central Intake staff, fax reports, and walk-in reports.

[12] National Adult Protective Services Association (NAPSA) Adult Protective Services Recommended Minimum Program Standards

or screened out as soon as possible, but no later than 24 hours after the report is received. Face-to-face visits are recommended within 24 hours for emergency situations (such as risk of death, irreparable harm, or significant losses of assets and/or property) and within one to five business days for less severe or imminent cases.

RECOMMENDATIONS

1. APS should establish a policy that addresses the time between report submission and Central Intake's acceptance or rejection.
2. APS should monitor the amount of time between report entry and the face-to-face visit to ensure that abuse, neglect, or exploitation victims—particularly those in situations requiring priority status—are being served in a timely manner.
3. APS should consider changing its business hours to allow for the ability to review and respond to cases in a more timely manner.

DHS Response: *DHS noted that "APS investigators are not first responders, nor do they provide emergency services" and reporters are directed to 911 in the event of emergencies or threats of imminent danger. DHS indicated that it believes the policies surrounding investigator response to priority and standard intakes are confusing and require review. APS continues to review both policies and procedures to address the time between report submission and Central Intake's acceptance or rejection. DHS indicated that it did not agree with the recommendation to change its business hours because "[Central Intake] staff who report at 7 a.m. concentrate on processing messages, web and fax reports until live call reporting opens at 8 a.m. When receipt of live calls ends at 5 p.m., [Central Intake] staff who end their day at 7 p.m. also concentrate on processing messages and web and fax reports."*

Finding 3: APS lacks a systematic process to ensure intake decisions are appropriate.

APS decisions on whether to accept a case appear inconsistent. We identified instances in which cases were unjustifiably rejected or were categorized as standard when allegations indicate they should have been categorized as priority. Also, APS management lacks a systematic process to ensure decisions are monitored for consistency and appropriateness. As a result, vulnerable adults may not receive appropriate services.

Best practices[13] recommend that adult protective services programs have a systematic method, means, and ability to promptly receive reports of abuse, neglect, or exploitation and determine whether a case will be screened out, accepted for investigation, or referred to another agency. As such, intake processes should have a standardized method for eliciting and documenting the content of an abuse, neglect, and exploitation report, which may include documenting the victim's circumstances and using a standard screening tool to evaluate safety and risk factors. This helps ensure that sufficient information is obtained and documented to justify a case's

[13] National Adult Protective Services Association (NAPSA) Adult Protective Services Recommended Minimum Program Standards

acceptance or rejection, and reports with similar allegations and circumstances result in similar decisions.

Our review of intakes and the associated case file received in fiscal year 2018 identified instances in which APS intake staff was inconsistently and potentially incorrectly determining whether and how a case should advance to investigators. As a result, some victims of abuse, neglect, or exploitation may not have received services as quickly as the allegations warranted, while other potential victims may not have been served. These issues are described below.

- **APS may be rejecting cases it should have accepted**. Our review of intake records identified that of the 6,300 cases rejected in fiscal year 2018, 41% (2,600) had no documented reason in the case file. We reviewed 54 rejected cases[14] for which a reason was documented and identified 15 (28%) instances in which the information in the electronic case file contradicted the decision. For example, one case (alleging exploitation) was rejected because, according to the intake report, the victim's address was missing; however, we found that the case file included an address. In another instance, the intake report indicated the case was rejected because the reporter did not make an allegation of abuse, neglect, or exploitation; however, information provided by the reporter and included in the intake case file described self-neglect. When we discussed these cases with APS management, they indicated that it was unclear why the reports were rejected and, in fact, the allegations warranted further APS investigation.

- **Cases with similar allegations are categorized differently**. As shown in **Exhibit 9**, fiscal year 2018 cases with similar allegations and circumstances were inconsistently categorized as either standard or priority cases. In one example, an allegation that included the victim being hit was categorized as standard, while a similar situation in which the victim was "bumped" was categorized as priority. As previously discussed, standard and priority cases have different timeliness requirements, and categorizing a case as standard may delay an APS investigator's visit and continue to put the victim at risk. In each of the four cases in **Exhibit 9**, the alleged perpetrators had access to the victims, which, according to APS policy, requires the case to be categorized as priority.

- **Cases are not categorized in accordance with APS policy**. Our review of accepted intakes indicated that Central Intake is not consistently following policy when categorizing cases. For example, approximately 40% of fiscal year 2018 intakes with allegations of sexual abuse (73 of 183) were classified as standard cases, despite an APS policy stating that such allegations should be designated as priority.

[14] The files for review were randomly selected and was not a statistically valid sample that can be extrapolated to the entire population.

Exhibit 9
Cases with Similar Circumstances/Allegations Detailed in the Intake File are Categorized Differently

Example #1	Categorization	
Allegations	**Standard**	**Priority**
Both cases involved allegations of: • Abuse • Exploitation • Emotional Abuse	**Case 1** 1. Alleged perpetrators (mother and step-father) live with the victim. 2. Mother physically attacked victim. 3. Step-father yells at victim. 4. Step-father refuses to release victim's disability check so that he could move to a Personal Care Home (PCH).	**Case 2** 1. Alleged perpetrators (daughter and son-in-law) live with victim. 2. Son-in-law has pushed/shoved victim. 3. Both perpetrators yell/scream at victim. 4. Perpetrators do not work-exploit victim; threaten to withhold granddaughter if the victim refuses to cooperate.

Example #2	Categorization	
Allegations	**Standard**	**Priority**
Both cases involved allegations of: • Abuse • Exploitation • Emotional Abuse	**Case A** 1. Alleged perpetrator is house parent in unlicensed Personal Care Home (PCH). 2. Perpetrator has hit the victim one time.	**Case B** 1. Alleged perpetrator (grandson) lives in the home. 2. Grandson has not hit the victim but has bumped into the victim.

Source: DOAA review of APS case files

Central Intake staff generally have discretion regarding whether to accept a case and then how to categorize it (priority or standard). Based on our review of rejected intakes, information provided in the case file may be insufficient for making such determinations. Additionally, APS personnel indicated that web reporting is often problematic because anyone can make a report through the web and reporters may not include sufficient information. In contrast, DFCS (child welfare system) limits web reporting to mandated reporters who have had training to ensure quality reporter information.

At the time of our review, APS management did not review intake decisions to ensure cases are properly and consistently assessed. Following discussions with the audit team, APS implemented a case review process that requires Central Intake supervisors to review two intakes per Central Intake Specialist per month. Additionally, the Program Integrity unit within the Division of Aging Services will review intakes to determine whether they meet criteria for investigation. Such strategies should also identify potential training necessary for staff (such as how to sufficiently document information and reasons for acceptance and rejection or APS policy requirements for categorizing priority cases).

RECOMMENDATIONS

1. APS should continue to improve its monitoring process to ensure consistency in which reports are/are not accepted for investigation. This could include using an intake script.
2. APS should improve controls over web reporting to improve the quality of data captured.
3. APS should ensure that all decisions are documented and provide sufficient justification for the reason.
4. APS should improve training for Central Intake staff related to categorizing reports as priority vs standard and justifying such decisions.

DHS Response: *DHS indicated that it "concurs that APS processes can be improved but disagrees that APS lacks a systematic process to ensure intake decisions are appropriate. Since the time period of the audit, APS revised the intake case record review process in addition to requiring CI Supervisors review all priority cases to determine accuracy... Additionally, an audit of intake reports will be performed quarterly by DAS Program Integrity (PI) section. This external audit will identify additional training necessary for CI staff and serve as a quality assurance review for the case record review process. APS has and continues to use an intake script for CI Specialists as a guide when taking reports." DHS indicated that APS is working on improvements to the current web intake report in order to facilitate more timely determinations by CI and updated the DAS website to instruct reporters to contact 911 in emergency situations. DHS is also considering potential automated solutions to assist in this area. Finally, DHS noted that as part of the APS training plan implemented in July 2017, APS began targeting ongoing training for CI Specialists based on performance improvement needs. Additional improvements to CI training were implemented in January 2020 and require monthly training based on case record review findings. Finally, APS will provide additional training focused on APS intake policy for making priority decisions and properly documenting justifications. Additional training will be provided to CI staff on properly documenting justification decisions.*

DOAA Response: *We found that APS did not have a systematic process in place during the audit; however, after discussing preliminary findings with APS staff, APS instituted a review and audit process.*

Finding 4: Improved coordination between APS and law enforcement is needed to ensure that victims of abuse, neglect, or exploitation are provided services they need.

While APS and law enforcement work with victims of abuse, neglect, or exploitation, there is limited communication and coordination among the entities. Without such coordination, victims of abuse, neglect, or exploitation incidents (which may also be criminal offenses) may not obtain the full scope of services they require. Some law enforcement officials we surveyed and interviewed indicated that they were unfamiliar with APS and its responsibilities, as well as the tools available to them.

Surveys and interviews with representatives from various law enforcement entities[15]—including Georgia Bureau of Investigation (GBI) regional offices, sheriff's offices, police departments, and district attorneys' offices—indicate there is limited communication and coordination with APS. For example, in our survey, 24% (38 of 156 respondents) of local law enforcement agencies and GBI regional offices indicated they never or rarely coordinate or work with APS related to an investigation of abuse, neglect, or exploitation that they are conducting. In addition, 20% (22 of 112) of survey respondents indicated that APS rarely or never follows up with law enforcement about abuse, neglect, or exploitation reports. By contrast, the officials we interviewed were more familiar with the Department of Family and Child Services (DFCS) caseworkers' responsibilities regarding investigations. A DFCS manager we spoke with indicated they conduct outreach to local law enforcement, including periodically visiting each law enforcement agency.

One impact of the limited coordination is law enforcement utilization of tools provided by DHS to assist with abuse, neglect, or exploitation cases is limited, as described below.

- **Georgia Abuse, Neglect, and Exploitation (GANE) app**: The GANE, app provides tools and resources for law enforcement and other professionals who respond to crimes involving vulnerable adults. The app includes elder abuse statutes, screening tools for mental illness and physical abuse, neglect, or exploitation, contact information for social service and regulatory agencies, and the functionality to report missing adults with Alzheimer's disease. The GANE app can also be used by law enforcement to access Temporary Emergency Relocation Funds (TERF), described below. DHS utilization data shows that in fiscal year 2019, 222 law enforcement officers[16] were registered users of the app, and TERF had been accessed only 38 times in fiscal year 2020.[17] Approximately 65% of survey respondents (102) indicated they do not use GANE.

- **Temporary Emergency Relocation Funds (TERF)**: TERF is a resource that assists law enforcement with emergency placement of vulnerable adults in certain circumstances. Few law enforcement officials we interviewed and surveyed had used TERF (only three officials we interviewed and eight survey respondents affirmed utilization), while the majority were unaware of the funds.

- **At-Risk Adult Crime Tactics (ACT) Training**: ACT training provides education regarding identification and response to crimes committed against vulnerable adults. According to DHS, 1,320 law enforcement personnel[18] had taken the class since its development in 2011. Approximately 75% of survey

[15] The audit team surveyed members of the local police departments and Sheriff's offices in addition to the 15 GBI regional offices. We received 174 responses (159 law enforcement and 15 GBI). The audit team met with representatives from seven district attorney's offices, eight sheriff's offices, and 13 police departments in seven APS regions to obtain information related to the interaction and relationship with APS.

[16] According to POST Council records, there are approximately 50,000 POST certified individuals in Georgia, and at least 515 local police departments and sheriff's offices.

[17] Through October 2019

[18] This number may be inflated because law enforcement personnel may retake the class as laws change.

respondents (117) indicated that 10% or less of their sworn personnel had ACT training, and only seven of the 19 representatives we interviewed had participated.

APS may also increase its visibility to law enforcement (and other entities working with vulnerable adults) through the following groups:

- **Multidisciplinary Teams (MDTs)** – In 2018, the General Assembly amended state law to authorize district attorneys to establish MDTs for elder/disabled adult investigations. According to the O.C.G.A. §30-5-11, these MDTs are to coordinate and collaborate the review of and the responses to suspected instances of abuse, neglect, or exploitation, as well as *identify opportunities within local jurisdictions to improve policies and procedures in the notification of and response to abuse, neglect, and exploitation given local resources.* APS is a suggested member in the legislation, along with district attorneys, local law enforcement, GBI, and state healthcare agencies, among others. As of August 2019, four MDTs had been established under the new legislation and two more were in the process of being formed.

- **At-Risk Adult Abuse, Neglect, and Exploitation Work Group** - This group was established in 2012 to bring together state, local, and federal entities to identify obstacles and solutions for addressing abuse, neglect, or exploitation. This includes a large working group as well as a smaller Legislative Subgroup. The Legislative Subgroup meets periodically to discuss issues encountered and identify potential changes to the law or available resources to address issues. Members of the Legislative Subgroup include various law enforcement entities (e.g., GBI, Attorney General, local law enforcement offices) as well as state agencies such as the Department of Community Health. While DHS, Division of Aging Services, and APS have numerous members on the large working group, the smaller Legislative Subgroup does not currently include an APS representative.

Best practices[19] recommend that adult protective services programs create policies and protocols to promote their collaboration with other entities, as needed, during investigations and interventions to benefit victims. Law enforcement is a particularly important group because they are often first responders to abuse, neglect, or exploitation instances and are involved in criminal cases that likely warrant additional attention and support. O.C.G.A. §30-5-4 facilitates this relationship by (1) requiring law enforcement to report abuse, neglect, or exploitation occurrences to APS (discussed in the finding on page 8) and (2) requiring APS to notify law enforcement or a prosecuting attorney if they receive a report of a suspected crime.

RECOMMENDATION

1. APS should conduct outreach, especially to law enforcement, on its responsibilities to victims of adult abuse, neglect, or exploitation, as well as tools and resources available to address abuse, neglect, or exploitation.

[19] Administration for Community Living, U.S. Department of Health and Human Services Voluntary Consensus Guidelines for State Adult Protective Services Systems, September 2016

DHS Response: *DHS indicated that it agrees with the finding. DHS also indicated that as a part of its outreach efforts, APS supervisors and lead investigators offer training on the role of APS and available law enforcement resources, such as TERF and the GANE app to all law enforcement agencies in their assigned geographical areas. FSIU has also expanded its outreach to Emergency Medical Services (EMS) and other medical professionals, who are primary or secondary responders to emergencies. Finally, DHS noted that since the time period of the audit, state law was changed to authorize District Attorneys to establish MDTs in their circuits and local APS staff participate in all MDT meetings, along with other state and local agencies, as a collaborative approach in addressing abuse, neglect, and exploitation of disabled adults and elderly in communities throughout Georgia.*

Finding 5: Case closure is based on completing the investigation, which includes referring for services, rather than ensuring services are provided.

APS's policies/process does not require the cause of an abuse, neglect, or exploitation case to be resolved prior to case closure. As a result, victims may be left in the same situation or never receive the recommended services, creating instances in which APS must open a new case to investigate similar allegations. When victims do not receive necessary services, they are at higher risk for repeat occurrences, which often means APS will receive another report to investigate—in some cases just days or weeks after the initial investigation was closed.

During fiscal years 2014 to 2018, 13% (10,600) of investigations—representing approximately 7,600 victims—were repeat investigations. Of the 10,600 repeat investigations, approximately 3,800 (36%) had a complete investigation[20] conducted within 90 days of the prior case's complete investigation. Nearly 240 victims had at least five cases during the period reviewed and 5,936 victims had multiple cases with repeating allegations. Victims have the right to refuse services; it is not known what proportion of repeat cases are those in which the victim has refused services. Also, the lack of immediately available services at the local level may increase repeat cases.

Best practice guidelines[21] recommend that prior to closing a case, the victim's situation should be stabilized, with safety issues resolved or mitigated; if necessary, the case should be allowed to remain open to further decrease the risk of additional occurrence. In Georgia, however, case closure does not necessarily mean the victim's situation has changed or the victim has received the recommended services. APS policies and practices have limitations that, if addressed, could improve the likelihood that victims receive recommended services the first time they encounter APS. These limitations are described below.

- **APS does not follow up to ensure services are obtained.** Interviews with investigators indicated that once the victim has been referred for services, such as home health or case management through the ADRC, the case will be

[20] An investigation includes an initial face-to-face visit with the victim, contacting witnesses and others who may have knowledge of the situation, referring to services, and reporting to law enforcement if necessary—See **Exhibit 1** on page 2 for an overview of the investigation process. APS does not have a truncated/reduced investigation process to be used for repeat investigations.

[21] Administration for Community Living, U.S. Department of Health and Human Services Voluntary Consensus Guidelines for State Adult Protective Services Systems, September 2016

closed with no follow-up to ensure that the services have had the desired effect. Staff at eight of the 12 ADRCs confirmed this, stating APS investigators rarely or never follow up with the ADRC about victims that have been referred for service.

- **APS does not consistently document changes in victim risk from case initiation to closure.** APS investigators assess victim risk at the beginning of the investigation but do not consistently document whether the risk has reduced prior to closing the case. Though the electronic case management system does have a place to note whether risk has changed, it is not required to be included in the case file. One study we identified on adult protective services programs' services indicated that change in the victim's risk can measure an adult protective services programs' effectiveness and evaluated investigation outcomes based on whether risk was reduced, remained the same, or increased.

- **APS policy is to complete investigations within 45 days.** Seven (25%) of the 28 investigators and supervisors we spoke with indicated that there is pressure to meet deadlines and close cases within 45 days. One investigator we spoke with indicated that APS wants the investigators "to get in and get out to close an investigation" and another investigator indicated feeling rushed to close cases and that investigators "could do better quality work with more time" while a third investigator noted that it was "frustrating to close [a case] and not know if the person is okay."

We identified a series of cases that illustrate the impact of sometimes limited availability of needed services and what could happen when victims do not receive the recommended services prior to case closure. In September 2013, APS received a report of neglect for an 88-year-old man, and the investigator closed the case after the alleged perpetrator told the investigator that the victim's home health nurse has requested a hospital bed from the VA. In November 2013, a second APS report was received, and the investigator noted that the hospital bed had not been obtained. A third case was opened for the victim in November 2014 and was closed after the ADRC referred the victim to a personal care home. In February 2015, a fourth case was opened, and it was noted that the victim had not been placed in the personal care home because he needed a higher level of care. In this instance, services (revised home health hours) were put in place prior to case closure, and we did not identify any additional cases.

APS policies do contain provisions to allow cases to remain open when the victim's needs cannot be addressed within the 45-day timeline; however, this is not common practice. Of the 81,500 investigations that occurred between fiscal years 2014 and 2018, only 3% (2,500) had any activity related to on-going services. The practice has declined in recent years—in June 2007, approximately 2,000 were listed as ongoing, compared to only 133 cases in June 2017.

RECOMMENDATIONS

1. APS should consider changing its policy to ensure that services are in place prior to case closure. This may include using ongoing services more frequently and/or requiring investigators to follow up with victims and service providers regarding referrals. An alternative would be to develop a

process to follow-up on closed cases when the victim was referred to services but the services had not been received at the time of case closure.

2. APS should consistently document the results of its assessments of a victim's risk for abuse, neglect, or exploitation and whether the risk has changed. APS should monitor the results of the assessments to identify the need for additional resources or training.

DHS Response: *DHS agrees additional training is needed for staff on ongoing case management policies. The APS policies for ongoing APS services addresses short-term needs of clients who may need oversight until services are in place, which includes following up on referrals made to the ADRC or monitoring of adults with pending Guardianship and/or Conservatorship proceedings as a result of a petition filed by APS. DHS also indicated that it had received a Victims of Crime Act Assistance (VOCA)/Criminal Justice Coordinating Council (CJCC) grant, to pilot a program at two Area Agencies on Aging (AAA) to provide immediate access to case management and direct services through the AAA for clients who would normally be on a waiting list. Services are limited to 12 months or until the client is removed from the waiting list.*

Finding 6: APS could improve the investigative process by providing investigators with additional informational tools.

APS investigators have limited access to informational tools that could enable them to efficiently conduct investigations. In addition, investigators do not have a central inventory system or other means to identify service providers to meet victims' identified needs. As a result, investigators must conduct their own research, which may delay services to victims.

Investigators we interviewed indicated the investigative process is hindered by a lack of information as they prepare for victim meetings and subsequently identify services to assist them. APS investigators indicated that central intake reports often do not contain sufficient information to assist in preparing for victim meetings. As a result, they generally must search for the information themselves, which can create delays.

For example, investigators stated they often must drive to the address listed on the intake report to determine whether the victim lives there; if not, they must knock on neighboring doors to request assistance if they cannot contact the initial reporter for additional information. Such strategies require significant time and resources and may not even be effective at locating the victim. In some instances, investigators mentioned they will call a coworker who is a DFCS investigator for information such as safety concerns, prior history with the victim, addresses, and benefit information from SHINES or Georgia Gateway.

Investigation Initiation

As described below, several tools would assist investigators with efficiently and effectively performing their work. In some cases, these tools are available to APS investigators' counterparts at DFCS.

- **Accurint** is a web-based program APS uses to obtain current or other addresses, contact information, and known family members for victims that cannot be located. The program is only available to the three district managers and the field manager, who perform searches when investigators have exhausted other options (an estimated 20 searches per month). Investigators indicated it often takes several days to get search results. APS management stated access was restricted due to funding issues; however, DFCS caseworkers have access to a similar tool.[22]

- **Georgia SHINES** is the DFCS child welfare information system, which APS investigators could use to obtain information related to services received and history of contact with DFCS, including safety concerns, information regarding others living in the home, and services provided such as services related to disabilities. APS management was unaware that investigators did not have access to this system.

- **Georgia Gateway** is the state's integrated system for determining eligibility across multiple benefits programs.[23] APS investigators indicated that victims who are receiving state benefits are easier to locate because there is incentive to keep addresses updated. Additionally, the system could help determine whether adults under 65 years have a disability that qualifies them for APS intervention (e.g., participant in Aged, Blind, and Disabled Medicaid).

Referrals for Service

In addition to limited access to personal informational tools, investigators lack informational tools related to services or benefits. Apart from emergency situations, APS generally does not provide direct services to abuse, neglect, or exploitation victims. Rather, investigators refer victims to outside service providers (for-profit, nonprofit, or public) that the victims can afford. As described below, investigators identified a number of challenges with this process, which can delay or even inhibit victims from obtaining services they need to prevent future abuse, neglect, or exploitation occurrences.

- **No centralized inventory of service providers** – APS previously had access to a list of service providers maintained by the Atlanta Regional Commission but had since lost access to that system. Investigators stated that locating services for victims is an informal process in which each individual investigator (including new staff and those from other regions) must identify service providers on a case-by-case basis. APS management indicated that their case management system could be used to maintain an inventory of service providers that could be accessed by investigators.

[22] DFCS uses Clear® to find relatives and others who have significant relationships to their victims. Information that may be included in Clear® is current or previous addresses, telephone numbers, criminal history, relatives, and associates. According to DFCS personnel, DFCS has found Clear® to provide more comprehensive information than Accurint, which they previously used.

[23] These programs include Medical Assistance (e.g., Medicaid), Supplement Nutrition Assistance Program, Temporary Assistance for Needy Families, Special Supplemental Nutrition Program for Women, Infants, and Children, and Childcare and Parent Services.

- **No access to centralized benefit information** – As discussed previously, Georgia Gateway allows people to apply for, maintain, and renew benefits for five state health and human services programs. Without access to the system, investigators must contact these multiple programs to identify any benefits the victim receives or may be eligible for. Georgia Gateway can also be used to help victims apply for benefits, which investigators indicated is a time-consuming process.

- **Limited capacity of affordable service providers** – APS does not have funding to provide services and thus must rely on victims' resources (insurance or income) to pay for services. If victims do not have resources to pay for services, victims must be placed on waiting lists for services funded through other DHS programs (e.g., home delivered meals, personal care services, homemaker) in order to receive services at a reduced cost. As of April 2019, nearly 6,200 people were on DHS's waiting lists, which are prioritized based on relative need (according to DHS policy, those in the second tier—totaling approximately 2,500 people—will likely never be served unless their condition changes). Even when victims can afford services from private organizations, they may still be placed on waiting lists due to service capacity.

- **Confusion over emergency funds** – APS investigators have access to Emergency Relocation Funds (ERF) through DHS; however, there is confusion regarding when and how to use the funds. While some investigators we interviewed understood ERF was limited to living arrangements (e.g., personal care home, house repairs), others have routinely used the funds for additional purposes such as bedbug remediation. Additionally, while the APS general counsel stated ERF should not be used in unsubstantiated cases, APS management stated this was not considered.

RECOMMENDATIONS

1. APS should ensure investigators have sufficient information regarding victims' eligibility for APS services and participation in state benefits. This may include providing increased access to Accurint, Georgia SHINES, and/or Georgia Gateway.
2. APS should consider obtaining a subscription to an inventory of services that can be accessed by investigators.
3. APS should ensure that investigators are aware of ERF's availability and criteria for utilization.

DHS Response: *DHS indicated that it agrees with the finding. DHS also indicated that it concurs that increased access to certain systems would be beneficial for staff, and all APS supervisors have been given access to Accurint. DHS indicated that "APS staff have had access to a community service/resources database since transitioning to the Division of Aging Services in 2004." In January 2020, DHS renewed the Empowerline Pro contract with Atlanta Regional Commission (ARC), which gives APS investigators access to a statewide inventory of community services and healthcare providers to assist the aging and disability community. APS will ensure all new employees have user credentials and technical support required to access this database of services/resources. In addition, the training curriculum put in place in 2017 includes exposing new staff to resources in their*

communities. Finally, DHS noted that since the time period reviewed by this audit, APS has included Emergency Relocation Funds (ERF) training as part of biannual Supervisors and Managers meetings and the new employee training. APS also reviews training needs and addresses topics identified during monthly and annual staff meetings.

***DOAA Response**: During the audit, APS investigators did not have access to an inventory of services and relied on information from coworkers or their own self-prepared lists of service providers.*

Finding 7: GBI did not utilize an increase in fiscal year 2016 state appropriations for its intended purpose of eight additional GBI agents to specialize in elder abuse cases.

Rather than add eight agents to specialize in elder abuse cases, GBI trained one agent in each of its 15 regions in elder abuse to act as a resource for other GBI agents. The estimated workload for these agents on elder abuse cases equates to approximately two full-time employees. While these agents may work some abuse, neglect, or exploitation cases, they are not dedicated to these cases and there has not been a significant increase in elder abuse cases worked by GBI.

In an effort to increase state-level law enforcement involvement, the General Assembly gave GBI original jurisdiction for investigating abuse, neglect, and exploitation of vulnerable adults in 2012 (O.C.G.A. §35-3-4). Meaning, GBI has the duty and authority to identify and investigate cases of abuse, neglect, or exploitation and need not depend on requests for assistance from local law enforcement. To support an increase in state-level law enforcement investigations of abuse, neglect, and exploitation, the General Assembly added $1.6 million to GBI's state appropriation in fiscal year 2016. The appropriations act stated that increase was to "increase funds for personnel for eight agents to specialize in elder abuse cases."

As shown in **Exhibit 10**, the number of abuse, neglect, and exploitation cases as a percentage of GBI's total cases has not increased commensurate with the annual state appropriation of $1.6 million. In the 15 regions, abuse, neglect, or exploitation cases comprised between 0.6% and 3.3% of total cases—with one region opening only one abuse, neglect, or exploitation case since 2016. GBI indicated they do not provide assistance on all local law enforcement requests and do not track the number of declined cases. As a result, the total number of elder abuse cases that GBI could investigate is not known.

Exhibit 10
Average Number of Cases Opened Compared to the Total Number of Elder Abuse Cases Opened, Fiscal Years 2016-2019[1]

Fiscal Year	Total Cases[1]	Abuse, Neglect, and Exploitation Cases
2016	4,000	48 (1%)
2017	3,809	65 (2%)
2018	3,971	87 (2%)
2019	3,968	59 (2%)

[1]Total cases are cases worked by GBI Regional Offices and do not include specialty units such as major theft, commercial gambling, drug offices, Child Exploitation and Computer Crimes, etc.

Source: GBI Records, Survey of GBI Regional Offices, and Audit Team Calculations

GBI personnel reported that the agency has other mandates and initiatives that require significant resources to address, which reduces the personnel available for investigating crimes against older/persons with disabilities. These initiatives include investigating cyber tips received by the National Center for Missing and Exploited Children, opioid overdose investigations, gangs, and officer involved shootings/use of force investigations.

RECOMMENDATION

1. The General Assembly should determine whether it should continue to fund eight agents for elder abuse investigations.

GBI Response: *GBI stated that "subsequent to GBI receiving the funding for eight agents to specialize in at-risk adult cases, we identified eight regional offices where the agents would be assigned." Because there were seven regional offices that were not assigned one of the additional special agents, "we identified special agents in each of those remaining seven regional offices" to specialize in at-risk adult cases. This ensured "that the entire state would benefit from an agent with specialized skills" in at-risk adult cases. Previously, GBI has successfully instituted a similar regional office model to address crimes against children. This model has proven to be effective in leveraging resources, developing and providing training, creating opportunities for partnerships and information sharing, and integrating best practices.*

"To only use numerical data to quantify the work special agents do and the impact they have on these cases in Georgia is risky... For a multitude of reasons, these investigations are often more complex and time consuming than other investigations. In your method of calculating the percentage of at-risk adult cases the GBI opened compared to the number of total cases... opened, please consider that our agents open these abuse, neglect, and exploitation cases under a larger umbrella of cases, i.e. theft investigations, missing persons, death investigations, assaults or other categories that best fit the situation. The case is then earmarked as an at-risk adult investigation. Unfortunately, there are times when our agents inadvertently fail to tag the case as one which involves an at-risk adult." Upon receipt of the draft report, GBI instructed each office to review their FY19 cases, to ensure they had been

"properly tagged." In doing so, GBI reports that the number increased from 59 to 103 total cases in fiscal year 2019.

***DOAA Response**: GBI's description of specialized agents does not mean the agents are solely dedicated to elder abuse cases. Specialization is not the same as agents being totally dedicated. Unlike other crimes, such as child abuse, GBI does not track the number of investigative hours expended on at-risk adult cases. We agree these cases are complex just as child abuse cases are complex; however, we would expect investigative hours to be tracked and for there to be an increase in workload that is commensurate with an increase in funded positions and the addition of GBI's original jurisdiction for elder abuse cases.*

Appendix A: Table of Recommendations

Finding #1: Abuse, neglect, and exploitation of vulnerable adults is underreported, limiting APS's ability to serve victims and prevent future occurrences. (p. #8)
1. APS should improve its outreach to law enforcement specifically and other mandated reporters to ensure that they are aware of their legal responsibility to report.
2. APS should periodically analyze reporter data to identify types of reporters or areas of the state to target outreach efforts. For example, if APS identifies underreporting by a specific type of mandated reporter, they could reach out to governing boards or professional organizations (e.g., Board of Nursing, Sheriffs' Association) to further educate members regarding the statutory requirement.
3. The General Assembly should consider expanding O.C.G.A. §30-5-4 to statutorily require agencies that work with vulnerable adults or regulate the financial industry to report relevant occurrences to APS.
Finding #2: APS's policies related to intake may result in investigators' delayed contact with victims. (p. #12)
4. APS should establish a policy that addresses the time between report submission and Central Intake's acceptance or rejection.
5. APS should monitor the amount of time between report entry and the face-to-face visit to ensure that abuse, neglect, or exploitation victims—particularly those in situations requiring priority status—are being served in a timely manner.
6. APS should consider changing its business hours to allow for the ability to review and respond to cases in a more timely manner.
Finding #3: APS lacks a systematic process to ensure intake decisions are appropriate. (p. #14)
7. APS should continue to improve its monitoring process to ensure consistency in which reports are/are not accepted for investigation. This could include using an intake script.
8. APS should improve controls over web reporting to improve the quality of the data captured.
9. APS should ensure that all decisions are documented and provide sufficient justification for the reason.
10. APS should improve training for Central Intake staff related to categorizing reports as priority vs standard and justifying such decisions.
Finding #4: Improved coordination between APS and law enforcement is needed to ensure that victims of abuse, neglect, and exploitation are provided services they need. (p. #17)
11. APS should conduct outreach, especially to law enforcement, on its responsibilities to victims of adult abuse, neglect, or exploitation, as well as tools and resources available to address abuse, neglect, or exploitation.
Finding #5: Case closure is based on completing the investigation, which includes referring for services, rather than ensuring services are provided. (p. #18)

12. APS should consider changing its policy to ensure that services are in place prior to case closure. This may include using ongoing services more frequently and/or requiring investigators to follow up with victims and service providers regarding referrals. An alternative would be to develop a process to follow-up on closed cases when the victim was referred to services but the services had not been received at the time of case closure.
13. APS should consistently document the results of its assessments of a victim's risk for abuse, neglect, or exploitation and whether the risk has changed. APS should monitor the results of the assessments to identify the need for additional resources or training.
Finding #6: APS could improve the investigative process by providing investigators with additional informational tools. (p. #22)
14. APS should ensure investigators have sufficient information regarding victims' eligibility for APS services and participation in state benefits. This may include providing increased access to Accurint, Georgia SHINES, and/or Georgia Gateway.
15. APS should obtain a subscription inventory of services that can be accessed by investigators.
16. APS should ensure that investigators are aware of ERF's availability and criteria for utilization.
Finding #7: GBI did not utilize an increase in fiscal year 2016 state appropriations for its intended purpose of eight additional GBI agents to specialize in elder abuse cases. (p.#25)
17. The General Assembly should determine whether it should continue to fund eight agents for elder abuse investigations.

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the state's response to abuse, neglect, and exploitation of vulnerable adults, focusing on the operations of Adult Protective Services (APS). Specifically, the audit examines the extent to which

1. mandatory reporters are reporting,
2. APS has sufficient resources to investigate reports of abuse, neglect, and exploitation, and
3. APS's interventions address elder abuse, neglect, and exploitation.

Scope

This audit generally covered activity related to Adult Protective Services activities that occurred during fiscal years 2016-2018, with consideration of earlier or later periods when relevant. Information used in this report was obtained by reviewing relevant laws, rules, and regulations, interviewing agency officials and staff from APS and other state agencies as necessary; analyzing data and reports from the APS electronic case management system; conducting site visits of seven APS regions, 21 local law enforcement entities, and seven district attorney's offices; and conducting surveys of sheriffs' offices, police departments, GBI regional offices, District Attorneys' Offices, and the ADRCs.

The primary data set used to inform our objectives was fiscal year 2014-2018 APS intake and investigation data from the APS electronic case management system. We assessed the data used for this examination and determined that although the data were subject to various sources of error, we believe it represents a credible estimate given the limitations of the data.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. We reviewed internal controls as part of our work on Objective 2. Specific information related to the scope of our internal control work is described by objective in the methodology section below.

Methodology

To determine the extent to which mandatory reporters reporting cases/allegations to APS as required, and how APS monitors and encourages reporting, we conducted reviews of state law, interviews, surveys, and analyzed APS reports. We reviewed relevant laws related to reporting of abuse, neglect, and exploitation to APS and law enforcement to identify requirements and responsibilities related to reporting. We interviewed APS staff to determine how APS ensures that mandated reporters are reporting and what APS does to encourage reporting.

In order to determine if reports were made as expected, we researched national trends and studies to determine the expected rate of abuse, neglect, and exploitation and compared reports received to the population of vulnerable adults at the state and county level.

In order to determine if mandated reporters were reporting, we reviewed reports received during fiscal years 2016, 2017, and 2018 to determine the type of reporter and whether the reporter was a mandated reporter.

The audit team surveyed members of the Georgia Chiefs Association and the Georgia Sheriffs' Association in addition to the 15 GBI regional offices to obtain information related to their knowledge of elder abuse statutes, tools and resources available, and interaction with APS. We received 159 responses from local law enforcement and 15 responses from GBI.

The audit team conducted site visits at 7 APS regional offices in all 3 districts. During these site visits, the audit team interviewed 19 investigators and 9 supervisors. Regions were selected based on location, law enforcement survey results, APS investigation substantiatiation rates, the percentage of repeat victims, and law enforcement reporting activity. The audit team met with representatives from seven district attorney's offices, eight sheriff's offices, and 13 police departments in the seven APS regions visited to obtain information related to the interaction and relationship with APS.

We interviewed state agency personnel for agencies that serve or interact with similar populations to APS (Healthcare Facility Regulation in DCH, the Long-Term Care Ombudsman, Department of Behavioral Health and Developmental Disabilities, Division of Family and Child Services, Department of Early Care and Learning, Secretary of State, Department of Banking and Finance, Georgia Vocational Rehabilitation Agency, Department of Insurance, and the Disability Ombudsman) to determine if they are required to report and if they have policies and procedures related to reporting and analyzed APS reports to determine if these agencies had made reports to APS.

To determine the extent to which APS has a strategic plan to ensure that sufficient resources are available to investigate current and future reports of ANE, we interviewed APS management to determine whether APS had conducted a needs assessment to determine if it had the appropriate number and type of staff. We researched best practices related to timeliness in accepting reports and conducting investigations. We also compared APS Central Intake operating hours to report activity to determine whether APS was aligning its intake staff with peak report times. In addition, we reviewed productivity standards for intake and investigations and compared to actual performance and investigator caseload data. We reviewed the time elapsed from report submission to APS investigator contact with victims. We randomly selected 54 files to review based on factors that included report method, Intake staff, and reason for rejection. This selection is not a statistically valid sample and should not be extrapolated to the entire population of rejected reports.

We interviewed APS investigators and supervisors to determine if investigators have the equipment and training necessary to conduct investigations efficiently and safely. We interviewed DFCS personnel to compare the equipment and tools available to DFCS investigators. As a part of site visits and surveys, we asked law enforcement personnel about their familiarity and use of tools that DHS created for law enforcement to assist in investigations of abuse, neglect, and exploitation. In addition, we reviewed GBI's use of funds appropriated for additional GBI agents to specialize in elder abuse by interviewing GBI personnel, surveying regional offices, and reviewing GBI case activity data for fiscal years 2016-2019.

We identified deficiencies in internal control related to Central Intake's review and acceptance/rejection of reports which are discussed in Findings # 2 and 3.

To determine the extent to which available services and interventions address abuse, neglect, and exploitation, we interviewed APS staff regarding availability of services for APS clients, how service providers are identified, and how services are funded. We reviewed APS investigator use of emergency funds and requirements related to using those funds. We also reviewed state law and APS policies and procedures related to service provision to identify APS's responsibility related to service provision. We analyzed APS investigation data to determine if APS clients recidivate; we reviewed client files to determine the circumstances related to repeat investigations and reviewed the allegations to determine if there were repeating allegations. We reviewed APS investigation data to determine if APS keeps clients' cases open to ensure that services are provided appropriately. We surveyed ADRCs to determine how APS interacts with the ADRCs in obtaining services for APS clients.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision makers. For more information, contact us at (404)656-2180 or visit our website at www.audits.ga.gov.