The Interview for Decisional Abilities (IDA)

A TOOL TO ASSESS THE DECISIONAL CAPACITY OF ABUSED AND NEGLECTED ELDERS

Robert C. Abrams, MD
Weill Cornell Medicine, NY
Edith+Eddie

https://www.youtube.com/watch?v=kz_A8Lqc
NEw
Edith+Eddie: SPOILER ALERT

- Loving married couple in their mid-90s; both frail.

- Eddie cognitively intact and Edith with MCI; they struggle together.

- Edith’s 2 daughters are concerned. Edith’s house is in poor repair.

- Daughter #1 feels that Edith should be in a nursing home near her, hundreds of miles away. #2 disagrees.
Edith+Eddie

- No capacity assessment for Edith.

- Edith is referred for guardianship.

- The daughters are warring & Eddie is fragile, so the judge appoints an attorney as Edith’s guardian.

- Without meeting her, Edith’s guardian orders her moved to a nursing home hundreds of miles away, near Daughter #1.
Edith+Eddie

- The couple are separated in a wrenching scene.
- Edith fails to telephone Eddie at a pre-arranged time. He despairs.
- Eddie is hospitalized, lapses into a coma.
- Edith’s guardian does not permit her to travel to and say goodbye.
- Eddie dies at the end, Edith a few months later in nursing home.
Opportunities missed:

1) Frame the concern (allegation of neglect/inadequate self-care) as a capacity matter. There were no assessments of Edith’s decisional capacity* nor her medical, cognitive or mental health.

The consequence of the failure to assess capacity was that the matter defaulted to guardianship.
Edith+Eddie: Consequences of failure to determine decisional ability

2) If there must be a guardian, appoint one close to the situation, nominated ahead of need.

The obvious candidates were disqualified or overlooked.

The consequences were the appointment of a guardian who had never met Edith, the separation of a loving couple and the imposition of terrible cruelty.
Guardianship (Article 81 in New York State)

**Unmet needs** (housing, food, medicine, safety)

**Likelihood to suffer harm**

**No less restrictive measures** (insufficient alternative resources)

‘**Incapacitated person**’ (cannot *understand or appreciate* the nature & consequences of inability to provide for his/her needs).
5 documents to be placed under a magnet on refrigerator

1) Copy of will or trust re: disposition of assets

2) Name of Power of Attorney (POA) to manage finances by wish or necessity

3) Copy of living will re: general preferences for end-of-life care (e.g., DNR, respirators, feeding tubes, etc.)

4) Name of healthcare proxy agent

5) Nomination of preferred guardian
The Lancet commission: Dementia prevention, intervention and care, 2017

Key messages

1) The number of people with dementia is increasing globally
2) Be ambitious about prevention
3) Treat cognitive symptoms
4) Individualize dementia care
5) Care for family carers
6) Plan for the future
7) Protect people with dementia
NYCEAC: Protecting NYC’s most vulnerable older adults since 2009

*1) Enhanced Multidisciplinary Teams (EMDTs) of professionals and APS workers advising on complex cases of elder abuse or neglect

2) Vulnerable Elder Protection Team (VEPT)—Emergency Dept-based team to identify, treat, assure safety and collect forensic evidence for victims of elder abuse

3) Helpline for concerned persons (friends, family, neighbors, not victims or abusers)
NYCEAC: Protecting NYC’s most vulnerable older adults

4) Community and hospital-based case consultations for expertise in capacity; mental health; injury patterns; forensic accounting, safety planning. Some EMDT cases arise from consultations.

*5) IDA project (Interview for Decisional Abilities)
NYCEAC: Protecting NYC’s most vulnerable older adults

6) Focus groups with APS workers and medical professionals (to assess needs for medical education about elder abuse, e.g., when to call 911; assessing imminent risk; suicidality).

7) The Abrams Geriatric Self-Neglect Scale
EMDTs (Enhanced Multi-Disciplinary Teams)

• Advise on complex cases of elder abuse or neglect mainly from APS, also hospitals, sr. centers or community agencies.

• Clients not present—consults & meetings are for workers and professionals, about 20+ permanent members.

• Meetings 2x/mo. in Brooklyn (2010), Manhattan (2015).

• “Scaling up” to the other 3 boros of NYC by Fall, 2018. NYCEAC’s EMDTs are a national model.
Adult Protective Services (APS) in the USA

• APS organizations were established under a 1974 Federal block grant in all 50 states by 1981.

• APS intervenes in cases of adult mistreatment or neglect (in some states ages 18+, others 60-65 and older).

• APS workers do a preliminary assessment around whether a person at risk has the capacity to manage that risk—but workers have had no guide for the task.
NYCEAC’s definition of elder abuse

A single or repeated act, or lack of appropriate actions, toward an individual 60 years or older

Occurs within any relationship where there is an expectation of trust OR where the act is targeted against a person because of old age or age-related disability
NYCEAC’s definition of elder abuse

Elder abuse can be intentional or unintentional

Takes multiple forms, sometimes with a single victim

Can have life-changing consequences
Consequences of elder abuse

- Physical (morbidity, disability)

- Psychological (shame, remorse, depression)

- Unrecoverable loss of resources

- Changes in life course (earlier nursing home placement, guardianship entailing sweeping loss of autonomy and suspension of civil liberties)
Financial exploitation clip

https://drive.google.com/file/d/1mGP0YjYGCNEqawZgW9qMxZZoYbRo7Sbt/view
“She found comfort in a Brooklyn diner, then lost everything.” (NY Times May 28, 2018)

- 85-yr-old bereaved widow meets sympathetic waitress
- Starts paying waitress’ “urgent” bills
- Takes out $400 K reverse mortgage on fully-paid home
- Gives waitress the proceeds; used for drugs
- Home repossessed; victim now in nursing facility
- Waitress arrested, but money is gone
- **Victim says she still “treasures the memories” of friendship**
She found comfort in a Brooklyn diner, then lost everything
Capacity to make decisions

A quandary for APS workers is whether elderly individuals at risk for neglect or abuse have the capacity to make decisions to manage the risk; involves many EMDT cases.
Capacity to make decisions

In NYS capacity is:

- Decision-specific

- Legally decided by physicians in NYS, but APS workers are the ‘gate-keepers’ for capacity assessment in cases of abuse or neglect
Specifically, APS workers often confront refusal by abused or neglected elderly clients to accept vital services.
Lesson from the EMDTs: Refusal by victims of elder abuse or neglect to accept vital services

Reasons for refusal of APS services:

- Cognitive impairment
- Fear of the abuser
- Wish to protect child or grandchild
- Shame, denial, esp. in financial exploitation
- Lack of insight or judgment, esp. in cases of self-neglect
- Psychological trauma
APS workers are on front lines of tension between the right of self-determination and societal responsibility for vulnerable citizens (Sussman et al. 2015).
How are these matters resolved by APS in most states in the US?

1) APS worker decides whether to accept a client’s refusal of services or seek capacity evaluation by a licensed physician.

2) The physician or psychologist decides whether the client has capacity to make the decision.

3) If the level of risk is high and the client also has broad deficits that pose dangers to well-being, APS may seek guardianship (a judicial decision).
How are these matters resolved by APS in most states in the US?

4) If complete guardianship is imposed, the client reverts to the status of an unemancipated minor.

There is suspension of autonomy and civil liberties.

Voting rights, financial transactions and testamentary powers are voided. **Decisional capacity is moot.**

Family cannot visit without permission of the guardian.*
Survey of assessment of decisional abilities by APS agencies: A gap in training and practice

An obstacle facing APS “gate keepers” is the lack of a valid standardized method to complete a preliminary assessment of a client’s decision-making abilities.
Survey of assessment of decisional abilities by APS agencies: A gap in training and practice

• In some areas of the US decisional assessments are limited to cognitive screens.

• Others use general measures of mental health.

• Still others assess only specific risk areas, e.g., physical abuse or financial exploitation.

• Most APS jurisdictions use methods that are related but peripheral to decisional ability.
Unmet needs in assessment of decisional abilities by APS organizations:

**Relevance** for cases of elder abuse and neglect

**Comprehensiveness** or applicability to multiple types of abuse or neglect and to a wide range of clients, e.g., with MCI

**Standardization** to facilitate research on risks and outcomes across jurisdictions.

**A Scripted Training Program**
Decisional “building blocks”

1) understanding the general problem
2) insight or “appreciation”
3) reasoning
4) ability to express a choice (consistently)

Enter the IDA: Interview for Decisional Abilities

WHAT IS IDA?

A semi-structured interview for gathering information on decisional abilities of elderly APS clients suffering from neglect or abuse

A standardized framework for APS workers to engage in a meaningful conversation with clients about a risk
Enter the IDA: Interview for Decisional Abilities

WHAT IS IDA?

A component of the comprehensive APS assessment.

A documentation of the rationale for accepting refusal of services or referring; has no legal bearing by itself but can be presented as evidence in guardianship hearings.*
For whom do we use IDA?

- Persons 60 years or older
- Not severely cognitively impaired (can have MCI)
- Not acutely psychotic
- Ideal for APS client suffering from elder abuse or neglect but refusing vital services (the “signature” indication)
The IDA Team

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IDA funding

- New York Community Trust
- Administration for Community Living
- Div. of Geriatrics and Palliative Medicine, Weill Cornell Medicine, NYC
- NYCEAC
- Massachusetts Executive Office of Elder Affairs (EOEA)
- Dept. of Family Medicine and Geriatrics, Keck School of Medicine, USC
- Individual investigator grants from NIA
History and development of the IDA: A culture change for APS

• In response to a mandate from the U.S. D.O.J…

• In 2014-2017 NYCEAC received Phase I and II funding to develop, pilot and revise a decision-making ability assessment tool for use by NYC APS workers.

• A complementary training program was necessary because IDA required the acquisition, for APS workers, of a novel skill set.
History and development of the IDA

• Trainings for the first IDA (IDA 1.0) were conducted with 48 “line” APS workers in NYC in 2014.

• The training comprised 2 full days didactics and exercise separated by 6 weeks for experience using IDA in the field.
History and development of the IDA

• Changes in syntax and format of the IDA tool and training program were incorporated in 2016-2017.

• 2017 version was piloted with APS workers in MA, with adjustments to conform to that state’s legal definitions and language (IDA 3.0-MA).
History and development of the IDA

• In 2017 Univ. of Southern California (USC) was funded to test IDA with APS workers across California, using the MA version with slight modifications.

• A Spanish translation has been prepared for California.

• USC is planning large-scale evaluation and validation studies.
ADMINISTERING THE IDA TOOL

When and how to introduce the IDA 3.0

Anytime in the APS assessment interview but best after some rapport established; introduced as a series of “special and important” questions having to do with how the client sees his or her own situation

Length of time to complete the IDA: range 15-30 minutes
IDA: Summary of content and usage

Components of the IDA

- “Pre-IDA” (selection of risk)
- 3 main steps or anchor points, each with probes
- “Post-IDA” for next steps
IDA: Summary of content and usage
“Pre-IDA”

The “Pre-IDA” 3.0: Selection of risk to be discussed with IDA

Worker selects from a list the risk that involves the most imminent danger to the client, avoiding jargon.
IDA: Summary of content and usage: Step 1 (understanding)

Worker may use script but is encouraged to use own words

Step 1. Assesses understanding of the general problem. Establishes whether the client acknowledges that the risk or problem exists or has been experienced by others.

Step 1. Probe. Asks what happened or could happen in such situations. Consequences?

Step 1. Rating. Yes/No/Maybe. If firm “no,” stop IDA.

Step 1. Client’s words or paraphrasing that justified the score + notable gestures or affect.
IDA: Step 2 (insight or appreciation)

Step 2. Assesses **appreciation**, i.e., whether the client has insight into his own risk.
Clients may acknowledge a problem in general terms but disavow any personal involvement.

Step 2. **Probe.** Client is asked to elaborate on the story of his involvement with the problem or risk.

Step 2. **Rating.** Yes/No/Maybe.

Step 2. **Client’s words** or paraphrasing that justified the score + notable gestures or affect.
IDA: Step 3 (reasoning)

Step 3. Focuses on reasoning, i.e., client’s ability to weigh the advantages and disadvantages of a plan to address the risk.

Except if the client failed Step 2, he is asked if he has own plan. The worker selects one plan, either the client’s or APS’, for discussion.
IDA: Step 3 (reasoning)

The client is asked to consider, separately, the pros/cons of the plan for him. Plan details are deferred to other parts of the APS assessment. The client’s thinking, not the plan itself, is under scrutiny.

Step 3. Rating. Yes/No/Maybe.

Step 3. Client’s words or paraphrasing that justified the score + notable gestures or affect.
The “Post-IDA-3.0.” Here the worker indicates the client’s choice* and the future direction of the decisional abilities assessment.

Often the next step will be a discussion with an APS supervisor and a review of the worker’s judgments and supporting documentation before determining the disposition of the case.
# The Interview for Decisional Abilities (IDA)

## Pre-IDA 3.0-CA

Complete the questions below before conducting the IDA 3.0 - CA Interview.

<table>
<thead>
<tr>
<th>Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>APS Worker Name</td>
<td>Supervisor</td>
</tr>
<tr>
<td>Client Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

A. Check all the risk(s) that the client seems to be facing at this time:

<table>
<thead>
<tr>
<th>PERPETRATED BY OTHERS</th>
<th>SELF-NEGLECT</th>
<th>Physical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault/battery</td>
<td>Alcohol/substance abuse</td>
<td></td>
</tr>
<tr>
<td>Constraint or deprivation</td>
<td>Disregard for personal safety</td>
<td></td>
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<tr>
<td>Chemical restraint</td>
<td>Heavy chore responsibility</td>
<td></td>
</tr>
<tr>
<td>Over/under medication</td>
<td>Rejection of appropriate/adequate care</td>
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<tr>
<td><strong>Sexual Abuse</strong></td>
<td>Inadequate physical care (eg. personal hygiene, food, clothing)</td>
<td></td>
</tr>
<tr>
<td>Genital trauma</td>
<td>Health and Safety Hazards</td>
<td></td>
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<tr>
<td>Sexual assault/rape</td>
<td>Inadequate/dangerous housing</td>
<td></td>
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<tr>
<td>Unwelcomed kissing or fondling</td>
<td>Inappropriate/unsanitary home care</td>
<td></td>
</tr>
<tr>
<td><strong>Neglect</strong></td>
<td>Isolation (social/physical)</td>
<td></td>
</tr>
<tr>
<td>Abandonment</td>
<td>Locked in/out of home/room</td>
<td></td>
</tr>
<tr>
<td>Deprivation of goods and services</td>
<td>Malnutrition/dehydration</td>
<td></td>
</tr>
<tr>
<td>Physical isolation</td>
<td>Risk of suicide</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Neglect</strong></td>
<td>Financial Self-Neglect</td>
<td></td>
</tr>
<tr>
<td>Using funds without permission</td>
<td>Inability to manage finances</td>
<td></td>
</tr>
<tr>
<td>Changes to financial/estate/legal documents without understanding</td>
<td>Forced from home (eviction)</td>
<td></td>
</tr>
<tr>
<td>Unexplained loss of funds</td>
<td>Inadequate home utilities</td>
<td></td>
</tr>
<tr>
<td>Misappropriation of assets</td>
<td>Victim of consumer fraud or scams</td>
<td></td>
</tr>
<tr>
<td>Threats with intent to exploit</td>
<td>Financially destitute</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological/Mental</strong></td>
<td>Medical Care</td>
<td></td>
</tr>
<tr>
<td>Emotional trauma/ neglect</td>
<td>Neglects medical needs</td>
<td></td>
</tr>
<tr>
<td>Undue influence (sleep deprivation, unsafe deception, reward/punishment etc.)</td>
<td>Neglects mental health needs</td>
<td></td>
</tr>
<tr>
<td>Social Isolation/Confinement</td>
<td>Other (please describe)</td>
<td></td>
</tr>
</tbody>
</table>

B. Endangerment

Instructions: Write one risk from the risk(s) checked above

1. presents a high level of endangerment for the client.
2. What wording will you use to describe this risk to the client?

C. Consider how you will introduce IDA 3.0-CA to the client

For example: "Let’s talk now about some of the decisions that you might be making" Or “Now I’m going to be asking you some important questions having to do with decisions that you might be making. Will that be OK?"
Interview for Decisional Abilities 3.0-CA

Step 1

Interview Instructions: Use the risk identified in the Pre-IDA 3.0-CA for steps 1, 2 and 3.

Assessing Understanding of the Risk in General

A. APS worker asks client’s understanding that some people have the same risk that the client now confronts. One way to ask:

“I'd like to discuss your thoughts about whether you think that [insert risk] can happen to others?”

B. If the client understands that others can have the risk, worker asks the client to explain what could happen if the risk is not addressed. One way to ask:

“Suppose someone faces [insert risk], what might happen to him/her?”

Worker Judgment

*Essential Element*

Do you think the client understands the risk in general?

Check 1: □ YES □ MAYBE □ NO  Instructions: if NO, do not complete IDA 3.0-CA and talk to your supervisor.

What did the client say that brought you to this decision?

Notable observations, if applicable (e.g., client’s emotions, reactions, non-verbal):
Step 2
Assessing Insight into the Risk on a Personal Level (Appreciation)

A. APS Worker asks the client if he/she is experiencing this risk. One way to ask:

“I'd like to learn more about you. Even though we may have already touched on this in our conversation, do you think you are facing [insert risk]?”

Possible probes:

“Can you tell me why?” or “I'd like to know more about your thoughts on this.”

Worker Judgment
*Essential Element*
Do you think the client has insight that he/she could personally be experiencing this risk?
Check 1: □ YES □ MAYBE □ NO

Instructions: If NO, in Step 3, skip question A and complete only questions B and C.

What did the client say that brought you to this decision?

Notable observations, if applicable (e.g., client’s emotions, reactions, non-verbal):
Step 3
Assessing Ability to Weigh Pros/Cons of a Plan for Addressing Risk (Reasoning)

A. APS worker asks what the client plans to do about the risk. One way to ask:
   “What are your plans to address the possibility of [insert risk]?”
   “How would that help address the possibility of [insert risk]?”

B. If necessary, APS worker asks about an alternative plan to address the risk. One way to ask:
   “Would you consider accepting [insert plan] to address the possibility of [insert risk]?”
   “Anything else you want to do about the possibility of [insert risk]?”

C. APS worker asks the client about pros and cons of either the plan to address the risk. One way to ask:
   “What would be the advantage for you having [insert plan] to address the possibility of [insert risk]?”
   “What would be the disadvantage for you having [insert plan] to address the possibility of [insert risk]?”

Worker Judgment
*Essential Element*
Does the client have the ability to weigh the pros/cons of a plan to adequately address the risk?
Check 1: [ ] YES  [ ] MAYBE  [ ] NO
What did the client say that brought you to this decision?

Notable observations, if applicable (e.g., client’s emotions, reactions, non-verbal):
**Interview for Decisional Abilities 3.0-CA**

**POST- IDA 3.0-CA: Next Steps**

**Risk:** ______________

<table>
<thead>
<tr>
<th>Worker Judgment</th>
<th>Yes</th>
<th>Maybe</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Understands</td>
<td></td>
<td></td>
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<tr>
<td>Step 2: Insight (Appreciates)</td>
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<tr>
<td>Step 3: Reasons</td>
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</table>

**Next Steps:**
Please check all that apply:

- [ ] Incorporate IDA 3.0-CA with other elements of your assessment to develop a case management plan.
- [ ] Discuss case with supervisor
- [ ] Consider referral for professional capacity assessment
- [ ] Other ____________________

Estimate time conducting the IDA 3.0-CA interview: ______________
The “pre-post” test for APS IDA trainees

INSTRUCTIONS TO TRAINER:

After the post-test is collected, review the answers with the learners.

Post Test Answers

1JT F If a person has significant cognitive impairment, h/she would definitely lack capacity to make decisions.
Say:
False. It is possible to have significant cognitive impairment in some areas of thinking but not in others. Therefore, this person could have capacity to make some decisions.

2JT F If a person understands a problem in general, h/she would then also understand how it applies to him/her personally.
Say:
False. It is possible to understand a problem in a general sense, as it applies to others, but at the same time lack insight into how the problem affects the person himself or herself.

3JT F The value of gathering information about decision-making abilities is only to determine whether or not to refer for a professional capacity evaluation.
Say:
False. Gathering information about decisional abilities can also be useful in understanding how a person thinks and his or her ability to accept or refuse services.

4JT F If a person accepts a service to address a risk h/she is facing the person is definitely demonstrating decision-making ability.
Say:
False. A person might accept a service without understanding the underlying problem or without having insight into how it affects him or her personally.

5JT F It is possible for a person to have adequate decision-making ability and still make a decision that puts him/her at risk.
Say:
True. This refers to the right to self-determination. People have a right to make decisions that may place them at risk, provided that the risk is not life-threatening.

6JT F If a person accepts a service to address a risk, h/she lacks adequate decision-making ability to make other decisions.
Say:
False. It is possible to have adequate decision-making ability for one decision but not for another one. For that reason, we say that decision-making ability is decision-specific, that is, it is judged separately for each decision faced by the person.

7JT F An APS worker’s documentation obtained during a person’s interview can be used in court.
Say:
True. APS worker’s documentation, particularly of statements made by the person, can provide evidence in a court proceeding, for example, in a guardianship case.

8JT F If a person has no cognitive impairment, h/she would definitely have the capacity to make decision(s) regarding risk.
Say:
False. A person may have no cognitive impairment but at the same time have poor judgment that places him or her at significant risk. Therefore, it is possible to lack capacity for a decision despite the absence of cognitive impairment.

9JT F In CA, only a psychiatrist is legally able to sign a medical certificate that determines someone’s capacity for a particular decision.
Say:
False. In CA some medical and mental health professionals, including a physician, a certified psychiatric nurse clinical specialist, a nurse practitioner, and a licensed psychologist can sign a medical certificate that determines someone’s capacity to make a particular decision.

10JT F Experienced caseworkers do not need to rely on a standardized interview to assess a person’s decision-making ability.
Say:
False. Using a standardized interview to assess a person’s decision-making ability does not rely on intuition or "gut feelings" but uses a reliable and thorough method that can be communicated to others in the field. Other APS workers or professionals will then be able to see how a conclusion about decision-making ability was made.

INSTRUCTIONS FOR TRainers:

Tell the learners you will now move on to the certificate ceremony before ending for the day. Call each learner up to the front to receive his or her certificate.

End with saying: A final thank you to all of the learners for your exceptional dedication and effort in working towards making today a valuable and useful training.

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Directions for research

- Usefulness of the tool as judged by workers and end-users (physicians; psychologists; social workers; attorneys; courts)
- Evaluation of trainings
- Development of generic version*
- Validity
Immediate IDA outcomes: Refusal of services

Client **refuses** services but has **adequate** understanding, appreciation and reasoning around the risk.

Client **refuses** services but has **poor or equivocal** understanding, appreciation and reasoning around the risk.

Client **refuses** services and has **adequate** understanding, appreciation and reasoning, **but severity of risk** leaves worker uneasy or there is inconsistency between action and words.
Immediate IDA outcomes: Acceptance of services

Client **accepts** services and has **adequate** understanding, appreciation and reasoning around the risk.

Client **accepts** services but has **poor or equivocal** understanding, appreciation and reasoning around the risk*.
Future research strategies: validity

Since there is no consensually-agreed “correct” disposition in APS cases, consider evaluating concordance between IDA documentation and dichotomous dispositions:

• APS acceptance of client’s decision about protective services

• APS referral for professional capacity assessment and/or guardianship
Research strategies: validity/concordance

A randomized control group would use methods of assessment and documentation in place before IDA (but there are many).
Other approaches to IDA validation

Initial validity and reliability assessments after training

Show filmed case study with core IDA concepts embedded. Ask workers who have been IDA-trained and control workers who have NOT been trained to rank the 3 IDA steps based on the evidence presented.

Have workers learned the fundamentals? Do they make the correct judgments (vs. controls)?
IDA summary

- IDA 3.0 has been integrated into the practices of APS in NYC and Massachusetts.

- A large-scale project to introduce IDA 3.0 in urban and rural counties of California has been launched.

- Focus groups with NYC trainees have mostly reflected satisfaction with IDA, and surveys have showed new learning.

- Validity and reliability studies are pending, including benefits for professional end-users.