

Aging and Elder/Dependent Adult Abuse Assessment and Reporting CE/CEU Course 10 hours/Units

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1. Detecting Elder Abuse And Neglect: Assessment And Intervention

Elder mistreatment includes intentional or neglectful acts by a caregiver or trusted person that harm a vulnerable older person. It can occur in a variety of settings. One out of 10 older adults experiences some form of abuse or neglect by a caregiver each year, and the incidence is expected to increase. Although the U.S. Preventive Services Task Force found insufficient evidence that screening for elder abuse reduces harm, physicians in most states have professional and legal obligations to appropriately diagnose, report, and refer persons who have been abused. Screening or systematic inquiry can detect abuse. A detailed medical evaluation of patients suspected of being abused is necessary because medical and psychiatric conditions can mimic abuse. Signs of abuse may include specific patterns of injury. Interviewing patients and caregivers separately is helpful. Evaluation for possible abuse should include assessment of cognitive function. The Elder Abuse Suspicion Index is validated to screen for abuse in cognitively intact patients. A more detailed two-step process is used to screen patients with cognitive impairment. The National Center on Elder Abuse website provides detailed, state-specific reporting and resource information for family physicians. The National Center on Elder Abuse defines elder abuse as “intentional or neglectful acts by a caregiver or ‘trusted’ individual that lead to, or may lead to, harm of a vulnerable elder.” Although some authors draw distinctions among mistreatment, abuse, and neglect, this article uses the terms inclusively and interchangeably.

Abuse appears to occur most often in domestic home situations, and may be perpetrated by adult caregivers, family members, or other persons. It may also occur in institutional settings such as long-term care facilities, nursing homes, or hospice. Older patients (older than 75 years) tend to have more risk factors (i.e., shared living arrangements, cognitive impairment with disruptive behaviors, social isolation from family and friends, caregiver mental illness [e.g., major depression], alcohol misuse, and caregiver dependency on the older person [e.g., financial]). These same risk factors can be barriers to detection of abuse. Not all patients who experience abuse readily demonstrate or express risk factors, and, conversely, many patients with risk factors are not being mistreated.

Key Recommendations for Practice

CLINICAL RECOMMENDATION

Routinely inquire and assess for risk of and suspected elder abuse.

Screening for cognitive impairment should be performed before screening for abuse in older persons.

Disease-oriented evidence- Patients and caregivers should be interviewed separately when screening for elder abuse.

COMMENTS

The Elder Abuse Suspicion Index can be used to assess about risk factors for elder abuse.

Physicians should be aware of medical conditions and medication effects that can mimic abuse in older persons.

Specific patterns of injury are more suspicious for intentional injury in older persons.

A Growing Problem

Over the next 20 years, the geriatric proportion of the U.S. population is projected to increase from 12% to 31%.^{10–12} Family physicians can expect more instances of elder abuse because larger numbers of older persons will need medical care. As more states mandate reporting by physicians (most already do), there will be increasing obligations for detection and assessment. Despite this expected increased demand for expertise, physicians generally lack training, experience, education, and adequate guidelines for the assessment and management of abuse. Less than 2% of reports of elder abuse and neglect to state APS agencies come from physicians. A survey of family physicians and internists found that more than 80% of them could not recall any medical school or residency training in this area. Another survey showed that 44% of residency program directors report actively screening patients for elder abuse.

Screening

The U.S. Preventive Services Task Force found that current evidence is insufficient to assess the balance of harms and benefits of screening all older or vulnerable adults for abuse and neglect. At this time, there does not appear to be supportive evidence that screening and early detection of elder abuse and neglect reduce exposure to abuse, or physical or mental harm from abuse. The Joint Commission, National Center on Elder Abuse, National Academy of Sciences, and American Academy of Neurology recommend routine screening, and the American Medical Association recommends routine inquiry. Identification of and intervention in abuse are considered by many to be a professional responsibility for physicians and are an accreditation requirement for hospitals. The University of Maine Center on Aging, Maine Partners for Elder Protection recommends screening once or twice yearly.

It is not clear if using specific screening protocols decreases the incidence or impact of elder abuse any more than simply having a generally increased threshold of suspicion.⁵ Validated screening instruments are available for physicians to consistently and systematically inquire about abuse. If a family physician chooses, preventive health visits may function as a reasonable occasion for screening.

THE ELDER ABUSE SUSPICION INDEX

Few instruments designed to detect risk of or suspected abuse have been validated in primary care settings. The Elder Abuse Suspicion Index (EASI) was validated in a primary care setting and can be used by physicians to screen cognitively intact patients during routine visits (Figure 1). It has a sensitivity of 0.47 and a specificity of 0.75. The EASI includes five patient-answered items, plus one physician question that can identify patients who are at risk. At least one “yes” response to questions 2 through 6 indicates a need for further assessment.

The Elder Abuse Suspicion Index (EASI).

Screening older patients for mistreatment may follow a one- or two-step process, depending on the patient's level of cognitive function. When the physician has known a normally functioning, cognitively intact patient over time, one-step screening using the EASI is recommended. When the physician does not know the patient or suspects dementia, the two-step process begins with screening for cognitive impairment with the Mini-Cog. It can be administered in less than five minutes and has comparable sensitivity and specificity to the well-known Mini-Mental State Examination. If the Mini-Cog is negative for dementia, the physician may administer the EASI. If the Mini-Cog is positive, further assessment should clarify cognitive impairment before

screening for abuse. Cognitive deficits may be limited to specific domains, and a patient may retain memory and capacity in others.

Medical History

Patients who present with injuries or signs of abuse should be evaluated and appropriately referred. Begin by asking open-ended questions, such as “Can you tell me what happened?” and “What do you remember about how this injury occurred?”

INTERVIEW PATIENT AND CAREGIVER SEPARATELY

An older patient's neurologic, cognitive, or psychiatric conditions and family dynamics may create barriers to obtaining a reliable history. Fear of retaliation, shame, dependency on the caregiver, and lack of privacy may hinder disclosure. Using neutral, nonjudgmental questions, family physicians should encourage patients and caregivers to provide detailed information. Interviewing the elder alone, when possible, is paramount. Some older persons have such high dependency on caregivers for navigating health care systems that they are unable to give a one-on-one interview. A potential red flag for the possibility of elder mistreatment is a caregiver who often interrupts the patient to answer questions for him or her. However, such behavior does not always indicate elder mistreatment, and it could be a compensatory behavior for a patient with cognitive impairment. A hovering and protective caregiver does not imply patient intimidation. Some families may not trust health care professionals based on past experiences. Responding with reassurance and sensitivity overcomes patient and family resistance in many, if not most, cases.

Physical Signs of Abuse

Physical findings specific to abuse are rare. Patterns of injury such as ligature marks; multiple burns; and bruises on the abdomen, neck, posterior legs, or medial arms do not generally originate from unintentional trauma such as falls. Physicians might not be able to accurately determine the age of bruises or burns; however, particular sizes, patterns, and locations may suggest intentional injury. The presence of unusual or unexplained fractures (e.g., spiral long bone fractures, first rib fractures) requires a more thorough skeletal survey and evaluation for metabolic bone disease.

Signs and Symptoms of Possible Elder Abuse or Neglect

- Bruising in unusual locations (not over bony prominences; on lateral arms, face, or back; larger than 5 cm)
- Burns in patterns inconsistent with unintentional injury or with the explanation provided (e.g., stocking or glove pattern, suggesting forced immersion)
- Decubitus ulcers, unless the result of unavoidable decline
- Dehydration, fecal impaction
- Evidence of sexual abuse
- Intraoral soft tissue injuries
- Malnutrition, medically unexplained weight loss
- Missing medications
- Patterned injuries such as hand slap or bite marks; ligature marks or scars around wrists, ankles, or neck suggesting inappropriate restraint
- Poor control of medical problems despite a reasonable medical plan and access to medication
- Subconjunctival or vitreous ophthalmic hemorrhage
- Traumatic alopecia or scalp swelling

- Unexplained fractures
- Unusual delay in seeking medical attention for injuries
- Urine burns (similar to severe diaper rash), dirty clothing, or other signs of inattention to hygiene

No laboratory tests exist to definitively detect abuse. Undetectable levels of prescribed drugs may indicate medication withholding, which, in the case of a dependent older person with cognitive impairment, constitutes neglect. Caregivers may divert controlled substances for illicit use. Elevated therapeutic drug levels without medical explanation may indicate intentional or unintentional overdose. The presence of drugs or other toxins that are not prescribed may indicate poisoning. Coagulation studies and a platelet count can rule out a medical reason for abnormal or excessive bruising.

Body charts or clinical photographs (obtained with appropriate consent) are useful to document the location and shape of injuries such as bruises, skin tears, burns, and other skin conditions. If a recent sexual assault is reported or suspected, a forensic examination should be performed by a person with appropriate training and expertise. The central question for differentiating unintentional from intentional injuries is: “Is the explanation provided reasonably consistent with the physical findings?”

Management and Intervention

Depending on the acuity of the presentation, hospitalization may be necessary to provide treatment and protection during further evaluation or pending legal investigation. In the case of positive results on screening tests or other suspicion of abuse, actions are dictated by statutory reporting requirements. Family physicians will need to involve local social services and APS to determine options for disposition.

No consensus exists for a single standard algorithm for the evaluation and management of elder abuse. However, the general algorithm provided in Figure 2 is acceptable for most practice settings. Physicians may insert the statutory requirements for their practice location into the appropriate sections. A safety plan is an important element of the care plan in all situations.

Safety Plan for Older Patients Who Have Been Abused

A safety plan helps identify options for the patient and provides ideas to increase his or her safety. Each plan should be individualized, written down, stored in a safe place, and reviewed regularly by the physician, the patient, and a trusted friend or family member. A safety plan may include:

- Safe places to go, such as the home of a friend or family member, a shelter, or the hospital
- Strategies for reducing harm if the patient is going to continue to have contact with the abuser
- A checklist of essential items to keep together in a safe place (see Table 5 for resources and examples)
- Telephone numbers of family, friends, community organizations, and emergency service providers
- Special considerations, such as transportation needs, if the patient lives in a rural area
- A follow-up appointment with the family physician or referrals to other services

The Administration on Aging's National Center on Elder Abuse website (<http://www.ncea.aoa.gov>) is the most comprehensive online resource available on elder abuse. It

provides specific information on each state's laws defining elder abuse and mandatory reporting requirements; information on local contact agencies and numbers; links for state or local intervention resources; and information for caregivers and patients. Specific resources for each state are also available weekdays via the Eldercare Locator (telephone: 800-677-1116). Even when APS or law enforcement becomes involved, family physicians still bear significant responsibility for follow-up medical care of patients. Relationship continuity can support the patient and family in the process of healing and recovery.

RESOURCE	DESCRIPTION
Administration on Aging	Elder abuse tools and resources with information on how to protect older persons http://www.aoa.gov/AoARoot/AoA_Programs/Tools_Resources/index.aspx
American Medical Association	Policy regarding family and intimate partner violence http://134.147.247.42/han/JAMA/https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-515.965.HTM
Eldercare Locator	Resource for finding local resources by zip code or community http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx
National Clearinghouse on Abuse in Later Life	Training resources and videos, and links to other resources for health care professionals http://www.ncall.us
Pocket guide on elder investment fraud and financial exploitation	Information from Baylor College of Medicine's Texas Consortium Geriatric Education Center as part of the Elder Investment Fraud and Financial Exploitation program http://www.state.nj.us/oag/ca/bos/elder/PocketGuide.pdf
Response to Abuse in Later Life: A Self-Assessment Workbook for Domestic Violence and Sexual Assault in Victim Services	Self-assessment tools to assist communities in evaluating practices within and across key intervening agencies and building a coordinated response to elder abuse %202011.doc
University of Maine Center on Aging	Steps to develop a safety plan for older persons (from Maine Partners for Elder Protection pilot project) http://umcoa.siteturbine.com/uploaded_files/mainecenteronaging.umaine.edu/files/elderabusescreeningmanual.pdf

Data Sources: The search included Agency for Healthcare Research and Quality Evidence Reports, Cochrane Database of Systematic Reviews, Clinical Evidence, National Guidelines Clearinghouse, Institute for Clinical Systems Improvement, U.S. Preventive Services Task

Force, PubMed, and Google Professional. We used electronic libraries from the University of Tennessee Health Sciences Center, and the Oregon Health and Sciences University. Key terms: elder abuse and neglect; screening instruments for elder abuse, neglect; injury, wound, bruise patterns for elder abuse; mandatory reporting for elder abuse, neglect; and safety plans for elder abuse, neglect.

2. Elder Abuse Awareness and APS Services

Adult Protective Services

Adult Protective Services (APS) are provided in each State to elderly and disabled persons who are reported to be victims of abuse, neglect, or exploitation. The definitions used to identify older persons and disabled persons vary from state to state. Contact the Eldercare Locator at 1 (800) 677-1116 to find the appropriate state number to call.

How the System Works

- Someone suspects that a person who is elderly or has disabilities has suffered from abuse, neglect, or exploitation.
- Person calls the report into an abuse hotline or to a local APS office.
- Staff assign a priority to report depending on how urgent it seems to be.
- If emergency, staff immediately call law enforcement, emergency medical staff, or hospital, depending on the situation.
- Report is forwarded to local staff for investigation, or to other entity if the situation falls outside of APS jurisdiction.
- Local staff begin investigation.
- Staff may telephone someone who knows the alleged victim or visit with the alleged victim, depending on the situation.
- Based on what is learned, staff determine how to proceed.
- Local staff continue investigation.
- Alleged victims are visited within a certain timeframe, depending on the urgency of the case.
- Worker contacts other parties who might know about alleged maltreatment.
- Worker evaluates the information gathered, discusses case with supervisor as necessary, and decides if the person needs protective services.
- When staff cannot confirm maltreatment: The case is closed. Staff may refer the client to other resources in the community, as appropriate.
- When staff confirm the maltreatment: Facility investigators report their findings to the appropriate authority for action as needed.
- Staff who live in the community may offer services on a voluntary or involuntary basis depending on the degree of existing danger and the client's ability to understand the situation. Services may be direct and/or purchased or arranged through another agency or community resource. Victims who have the capacity to understand their circumstances have the right to refuse services, regardless of the degree of danger.
- Clients have the right to self-determination. Competent adults have the right to make decisions about their own lives, including the right to refuse help from adult protective services. In some states competent adults may refuse an investigation as well as services.

Definitions

Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. These definitions were provided in the law only

as guidelines for identifying the problems and not for enforcement purposes. Currently, elder abuse is defined by state laws, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect, or exploitation of the elderly. Broadly defined, however, there are three basic categories of elder abuse: (1) domestic elder abuse; (2) institutional elder abuse; and (3) self-neglect or self-abuse. In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity. Domestic and institutional elder abuse may be further categorized as follows:

- **Physical abuse** is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. It may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, it may also include the inappropriate use of drugs and physical restraints, force-feeding, and physical punishment.
- **Sexual abuse** is defined as non-consensual sexual contact of any kind with an elderly or disabled person or with any person incapable of giving consent. It includes but is not limited to unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.
- **Emotional or psychological abuse** is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.
- **Neglect** is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder.
- **Exploitation** is defined as misusing the resources of an elderly or disabled person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

(Adapted from the *National Center on Elder Abuse*.)

Obvious symptoms

are scratches, cuts, bruises, burns, and broken bones.

Neglect or self-neglect may result in starvation, dehydration, over- or under-medication, unsanitary living conditions, or lack of heat, running water, electricity, lack of medical care, and personal hygiene. Exploitation is misusing the resources of an elderly or disabled person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources. Abused elderly or disabled persons may be isolated, ill, without a capable person to care for them, or without resources to meet basic needs. If Adult Protective Services has determined that they are in a state of abuse, neglect, or exploitation, they are eligible for adult protective services. If clients are competent enough to consent to services, they have the right to:

- Receive protective services;
- Participate in all decisions about their welfare;
- Choose the least restrictive alternative(s);
- Refuse medical treatment; and
- Withdraw from protective services.

Possible Indicators of Abuse, Neglect, or Exploitation

The following descriptions are not necessarily proof of abuse, neglect, or exploitation. But they may be clues that a problem exists, and that a report needs to be made to law enforcement or Adult Protective Services.

Physical Signs

- Injury that has not been cared for properly
- Injury that is inconsistent with explanation for its cause
- Pain from touching
- Cuts, puncture wounds, burns, bruises, welts
- Dehydration or malnutrition without illness-related cause
- Poor coloration
- Sunken eyes or cheeks
- Inappropriate administration of medication
- Soiled clothing or bed
- Frequent use of hospital or health care/doctor-shopping
- Lack of necessities such as food, water, or utilities
- Lack of personal effects, pleasant living environment, personal items
- Forced isolation

Behavioral Signs

- Fear
- Anxiety, agitation
- Anger
- Isolation, withdrawal
- Depression
- Non-responsiveness, resignation, ambivalence
- Contradictory statements, implausible stories
- Hesitation to talk openly
- Confusion or disorientation

Signs by Caregiver

- Prevents elder from speaking to or seeing visitors
- Anger, indifference, aggressive behavior toward elder
- History of substance abuse, mental illness, criminal behavior, or family violence
- Lack of affection toward elder
- Flirtation or coyness as possible indicator of inappropriate sexual relationships
- Conflicting accounts of incidents
- Withholds affection
- Talks of elder as a burden

Signs of Financial Abuse

- Frequent expensive gifts from elder to caregiver
- Elder's personal belongings, papers, credit cards missing
- Numerous unpaid bills
- A recent will when elder seems incapable of writing will
- Caregiver's name added to bank account
- Elder unaware of monthly income
- Elder signs on loan
- Frequent checks made out to "cash"
- Unusual activity in bank account
- Irregularities on tax return
- Elder unaware of reason for appointment with banker or attorney
- Caregiver's refusal to spend money on elder
- Signatures on checks or legal documents that do not resemble elder's signature

Facts and Figures

- The U.S. has 44 million persons age 60 or older, and 36 million people with disabilities.
- In the most recent year studied, Adult Protective Services completed 364,512 investigations of abuse, neglect, or exploitation involving older persons living at home (in private, non-institutional settings). Of these, an estimated 43% were confirmed.
- In the last decade, the number of domestic elder abuse reports investigated by Adult Protective Services across the nation has increased by more than 150 percent.
- Almost 62% percent of all cases of abuse, neglect, or exploitation of adults living at home involve mistreatment by other people and 38% involve self-neglect.
- Domestic elder abuse is a family problem – almost 90% of abusers were family members.
- Men were the abusers in over half of elder abuse cases.

Issues Facing Vulnerable Adults

10 Concepts on Aging

The best time to learn how to grow old with dignity and grace is during the younger years, and the best place is everyday life. Understanding all aspects of the aging process enables us to understand more clearly those who are aged. The following general statements offer a foundation for studying the aging process.

- **Aging is Universal.** It is common to every population and is not just a modern-day phenomenon in western civilization.
- **Aging is Normal.** 'Growing up' is spoken of with respect; 'growing old' with fear. This fear develops from the stereotyped picture of aging as a loss of faculties, beauty, energy, and memory.
- **Aging is Variable.** Each individual ages in a unique way. The state of later life develops from former personal life patterns.
- **Dying is Normal and Inevitable.** It is difficult for many to accept the idea that while a full, satisfying life is being lived, death can be anticipated as a meaningful closure of life.
- **Aging and Illness are Not Necessarily Coincidental.** The stereotype image again lingers, but individuals should prepare for healthy old age through improved living habits in early and middle years.
- **Older People Really Represent Three Generations.** The group known as the "aged" covers the years 65-112, representing two, and often three, generations and may include parents, grandparents, and great-grandparents. No other age group includes such diversity.

- **Older People Can and Do Learn.** Capacity to learn new things and re-learn the old is not necessarily diminished by old age. Learning patterns may change from youth and the speed of learning may slow, but learning ability appears to be culturally determined, not restricted by years.
- **Older People Can and Do Change.** As one grows older, many adjustments become necessary. Mates die, housing situations change, new activities are developed, and new friendships established.
- **Older People Want to Remain Self-directed.** Where dependency on others for decision making exists among older people, it has often been learned as a direct result of loss of a sense of purpose and self-respect. To prevent this loss when older adults undergo life changes, their self-direction and sense of control should be maintained as much as possible, even if they become dependent in some ways.
- **Older People are Vital Human Beings.** Although physical disability is often associated with mental inadequacy, it should be recognized that the need for physical help in crossing the street does not mean that the person does not know where he is going.

(Adopted from the *Texas Department on Aging, Ombudsman Certification Manual.*)

Issues Facing Vulnerable Adults

Isolation

Isolation and self-neglect are common among people who are elderly or have disabilities. Isolation is defined as not participating in activities that require contact with people. Although this problem applies to people regardless of their education, income, ethnicity, geographic location, or social lifestyle, people who are most at risk of isolation are frail or chronically ill, widowed or divorced and live alone. They are also more likely to be female, may also have reduced resources, and may be members of a marginalized minority group. Isolation may lead to loss in personal integrity, estrangement from family and friends, inability to care for one's self and deterioration of the ability to think and make decisions. Isolation can result in self-neglect, which is a form of elder abuse when living conditions are potentially life threatening. Isolation may lead people to be self-neglecting to the point that they deny any physical or mental problems and refuse help from family and friends. Isolated people usually have less support and interaction from others (often due to the deaths of a spouse, friends or primary caregiver); reduced coping skills; are less able to make decisions; are at greater risk of depression, substance abuse, mental impairment, or mental illness; have lost self-esteem; and may be unable or refuse to accept changes or acknowledge a need for help. Isolation and self-neglect require individual or community intervention. Communication and attention other persons provide can improve the self-esteem and lifestyle of an isolated elder. They can act as confidantes, assist with errands or housekeeping, or meet transportation needs. People who are isolated can benefit from support groups for people living alone. Support groups are effective because they provide the opportunity for sharing experiences, mutual support, and problem solving. Intergenerational programs can help reduce isolation for older people. These might include community initiatives in which older people are recruited and trained to assist in child care centers and schools. Many other volunteer opportunities in hospitals, nursing homes, food pantries, battered women's shelters and other not for profit organizations exist which can both reduce isolation and restore a sense of purpose to an older person's

Depression

Everyone feels sad or blue sometimes. But when sadness persists and interferes with everyday life, it may be depression. Very treatable, depression affects about 15 out of every 100 adults older than age 65.

How to Recognize Depression--Recognizing depression in the elderly and people with disabilities is not always easy. Vulnerable adults with depression may not know how to explain how they feel. They also may fear that they will be labeled as "crazy" or as having character weakness. Vulnerable adults and their families may dismiss depression as a passing mood.

Common Symptoms--Symptoms may include persistent sadness, feeling slowed down, excessive worries about finances or health, frequent tearfulness, weight changes, pacing and fidgeting, difficulty sleeping, difficulty concentrating, and physical symptoms such as pain or gastrointestinal problems.

Causes--Since depression is commonly due to biological changes in the brain, it is likely to occur for no apparent reason. Biological changes to the brain and body, medical illnesses, or genetics may put groups like elderly people at greater risk of depression. A specific event like retirement or the loss of a partner or loved one may lead to depression--it is normal to grieve over such events, but if the grief persists, it may be a sign of depression. Illnesses such as cancer, Parkinson's disease, heart disease, stroke, or Alzheimer's disease may cause late-life depression. These diseases may also hide symptoms of depression.

Suicide and Depression--Suicide is more common in older people than in any other age group. The population of people older than age 65 accounts for 25 percent of the nation's suicides. Suicidal attempts or serious thoughts about suicide should be taken seriously and evaluated by trained mental health staff.

Treatment--Most people can improve dramatically with treatment, which may include psychotherapy, antidepressant medications, and other procedures. Psychotherapy can play an important role with or without medications. There are many forms of short-term therapy (10 to 20 weeks) that have proven to be effective. Antidepressants help restore the balance and supply of neurotransmitters in the brain. Mixing doses, taking the wrong amount, or suddenly stopping antidepressants may result in negative effects.

Caring for a Person with Depression--The first step is to make sure the person gets a complete physical checkup because depression may be a side effect of another medical condition. If the person is confused or withdrawn, accompany the person to the doctor, or where possible, arrange for an in-home assessment. The doctor may refer the person to a psychiatrist. If the person is reluctant to see a psychiatrist, try to assure the person that an evaluation is necessary to determine what treatment is needed. Other approaches would be to reduce the person's isolation by helping them to get involved with church activities, the local senior center or other community forums

Issues Facing Vulnerable Adults

What is Self-neglect?

Self-neglect occurs when individuals fail to provide themselves with whatever is necessary to prevent physical or emotional harm or pain. The reasons that vulnerable adults neglect their own needs are often complicated, and frequently people are unaware of the severity of their situation.

What are the signs? Some common signs that may indicate self-neglect include obvious malnutrition; being physically unclean and unkempt; excessive fatigue and listlessness; dirty, ragged clothing; unmet medical or dental needs; refusing to take medications or disregarding medical restrictions; home in a state of filth or dangerous disrepair; unpaid utility bills; lack of food or medications. What are the causes? Depression can cloud a person's view of the world and their circumstances, leading to self-neglecting behavior. Often, elderly people lose their

motivation to live due to their loneliness and isolation. Other reasons that elders neglect themselves can include unexpressed rage, frustration, or grief; alcoholism or drug addiction; and sacrificing for children, grandchildren, or others at the expense of their own unmet needs. Finally, mental or physical illness can quickly result in the deterioration of an elder's ability to adequately provide for their own needs. What can be done to help? As much as possible, respectfully involve the elder in the effort to determine the cause of their particular case of self-neglect. Sometimes understanding and cooperation can be reached simply by having someone acknowledge and discuss their situation with them. If appropriate, ask the question, "What would make life meaningful for you again?" Allow them to express their feelings; this could reveal both the cause of the problem as well as its solution. Depending upon the circumstances, other helpful actions could include: medical or dental treatment; anti-depressant medications; helping them get involved in a favorite old hobby or providing transportation to a social group; getting them a pet; confronting them with their self-neglect; getting family members involved. When drug or alcohol addiction is the issue, hospital-based treatment is frequently the best solution. Sometimes the cause of elders neglecting themselves is directly related to the influence of someone else in their life. Perhaps the elderly individuals are sacrificing their needs in order to care for grandchildren or an ill spouse. Intervening in such situations often requires extreme caution.

Medication/Substance Abuse

Using medications wisely and substance abuse are concerns that apply to all age groups. But due to several factors, the elderly and people with disabilities are at a greater risk for having trouble with both areas.

Using Medications Wisely. Medicines help people live longer and more productively every day. But because they are powerful substances, the consequences of using them can be dangerous, even deadly. Drugs can affect different people in different ways. The elderly are at risk of misusing medications because they generally take more of them than anyone else and because reactions to medications change as the body ages. People who are elderly or have disabilities need to take responsibility for finding out about the drugs they are using. They should give doctors, pharmacists, and health professionals clear information about their current medications. They should also consult with those same people to learn more about new medications prescribed for them. Taking several medications can get confusing. In fact, many people forget whether or not they have taken a medication. One way to ease confusion is to create a chart that contains the name of each medication, its side effects, and when it needs to be taken. The chart should also include a column to be checked-off once a medication has been taken. If several medications are taken daily at different times, people may use a container system. A container can be as simple as a cup or egg carton or as fancy as daily multiple pill containers available at drug stores. Caution: People who live in homes with children should be sure any container system is not accessible to the children.

Substance Abuse. Coping with a disability or aging isn't easy. Therefore, some people who are elderly or have disabilities may turn to drugs and alcohol. Others may have struggled with substance abuse for decades. Vulnerable adults must be aware that even small amounts of drugs or alcohol can seriously hurt them. Alcohol can produce a dangerous reaction with acetaminophen, antibiotics, antidepressants, muscle relaxants, or sleeping medication. Alcohol, marijuana, and other drugs affect memory, ability to solve problems, and reaction time. Prolonged use of alcohol, tobacco, and other substances may have serious long-term health effects. For more information about the risks of substance abuse, consult with rehabilitation specialists or health professionals or contact organizations such as Alcoholics Anonymous or Narcotics Anonymous. If people who suffer from chronic pain fear they are

abusing pain medication, they should consult with their doctor to learn about other pain-reduction methods such as special exercises and biofeedback.

Incontinence

BLADDER INCONTINENCE

What is it? The loss of the ability to control urination can range from minor leaking to the loss of large amounts of urine. It is a symptom, not a disease, and is not uncommon. In many cases the problem can be cured, or at least made more manageable. People with bladder incontinence should see their doctor, especially since it can be caused by another medical problem that needs treatment. Incontinence doesn't need to interfere with a person's quality of life.

What causes it? Some temporary causes of bladder incontinence include urinary tract infections, vaginal infection or irritation, constipation, or side effects of medication. Other causes are not temporary but can still be treated, such as weak pelvic floor muscles due to pregnancy and childbirth, hormonal imbalance, weak bladder, weak urethral sphincter muscles, overactive bladder muscles, blocked urethra, nerve disorders, and immobility.

Warning signs: Urine leakage that prevents activities or causes embarrassment; leakage that began after a surgery, such as a hysterectomy or prostate surgery; inability to urinate or urinating more frequently than usual; needing to rush to the bathroom and losing urine if you don't arrive in time; pain when urinating or when the bladder is filling.

What can be done? Treatment depends on what is causing the problem. Medications can include antibiotics for infections, hormone replacement therapy, and drugs for bladder or sphincter control. Other successful treatments include biofeedback, pelvic muscle exercises, bladder training, and dietary changes. In some cases surgery will be recommended by the doctor.

BOWEL INCONTINENCE

What is it? Incontinence is the loss of normal control of gas or stool. Its severity ranges from mild difficulty with gas control to severe loss of control over liquid and formed stools. This problem affects as many as 1 million Americans, and many effective treatments for bowel incontinence are available.

What causes it? Chronic constipation is one of the most common causes, since it weakens the muscles surrounding the intestine and bowel. Other causes are diarrhea; stress, nerve or muscle damage; emotional disturbance; improper diet; chronic laxative use; gynecological, prostate, or rectal surgery; hemorrhoids or rectal prolapse, and a decreased awareness of the sensation of bowel fullness.

Warning signs: Any difficulty in controlling gas or bowel movements that causes embarrassment or concern is adequate reason to consult a doctor. Any signs of bleeding should immediately be reported to your doctor.

What can be done? Sometimes simply changing a person's medication can cure the problem of bowel incontinence. Other treatments include dietary changes, simple muscle strengthening exercises, constipating medications, and biofeedback. In some cases, surgery may be required.

Dementia and Alzheimer's Disease

What is Dementia? Dementia is a medical condition that affects the way the brain works. Sometimes incorrectly referred to as "senility," it involves a gradual deterioration of cognition (thinking/information processing/decision making abilities, as well as memory). It also affects behavior to a point that interferes with customary daily living activities. Dementia can affect all aspects of mind and behavior, including memory, judgment, language, concentration, visual perception, temperament, and social interactions.

Contrary to popular belief, dementia is not a normal outcome of aging, but is caused by diseases that affect the brain. One of these diseases is Alzheimer's disease.

What is Alzheimer's Disease? Alzheimer's disease is a devastating condition that eventually erodes all cognitive and functional abilities, leading to total dependence on caregivers and eventually to death. It affects about four million Americans and prevalence of the disease increases dramatically with age. About five percent of all cases have been associated with a genetic tendency. The majority of cases affect the population on a random basis. Scientists are still researching possible risk factors that cause the disease, as well as treatment.

Communicating With People Who Have Dementia

It is important for caregivers to be conscious of their verbal and nonverbal actions when communicating with people who have dementia. What caregivers say and do can have a positive influence on the client. Through skillful communication, caregiving, family interaction, and management of the person's environment, caregivers can enhance the lives of people who have dementia.

- Try to be aware of everything a client may be doing. If he doesn't appear to be listening or receptive, leave the patient alone. Tell him that you understand he doesn't want to talk.
- Be sensitive to a client's nonverbal communication. Be aware of your nonverbal messages. Adopt positive, pleasant nonverbal behaviors to be reassuring and encouraging.
- Try to avoid situations that are known triggers to resistant behavior. Change how you introduce activities.
- Give patient as much control as possible.
- Explain what you are doing (again and again if necessary). If resistant behavior continues or worsens, stop.
- Make the client feel like you are there for him. Look directly at him and show you are giving him your undivided attention.
- If the client is able to converse, avoid ambiguous questions and ask "yes" or "no" questions whenever possible.
- Speak slowly with a calm, reassuring tone of voice. Use single words and simple sentences.
- Avoid distracting background noises.
- Give the client ample time to respond. Repeat question or instructions if there is no response within a couple of minutes.
- Be consistent. Use the same word for the same thing. Provide affectionate encouragement. Use diversion and humor to overcome resistance.
- Match your verbal communication to the client's ability.
- If a client is talking to you but not making sense, search for important clue words and repeat them back to show that you are connected with him.
- Break down tasks into individual steps to be done one at a time.
- Don't pretend to understand confused speech.
- Don't force the client to do anything.
- Don't attempt to force the person to be oriented to present-day reality.
- If the person is 'time-traveling' (appears to be re-living the past) demonstrate empathy with what the person is feeling about the past. Help the person review his or her life if he or she is able to reminisce.

Coping With Schizophrenia

Many adults come to the attention of protective services because of problems associated with schizophrenia. Not infrequently, the problems are associated with the client's noncompliance with medications or other treatments for their condition.

Preventing noncompliance through communication

- Noncompliance is a major reason that medications are not more effective in keeping people with schizophrenia out of the hospital. Persistent noncompliance may worsen the overall course of the schizophrenic illness. However, don't blame or scold the mentally ill person for stopping medication. Expect some amount of noncompliance, and try to understand what the reasons are, even if they are not rational. Find a perspective on medication that both you and the person with the illness can agree on. Persuade: Don't coerce.
- Have the person who is most influential with the mentally ill person do the talking. Focus on the possible day-to-day benefits of the drug. Try to match the notion of taking medication with achieving one's life goals. Find out what they want to accomplish and explain how medicines might help them get there.
- Try to have uniform agreement within the greater family about the need for medication. Otherwise, the person may play family members against each other. Do not get into a direct confrontation about medicine, especially when your relative is getting sick. Confrontation is counterproductive and can be very dangerous.
- Families and other concerned persons should understand and be genuinely sympathetic about the side effects caused by neuroleptic medications. Be sure the person with schizophrenia is informed in advance about the side effects of medications. A side effect will often be accepted if the patient has been warned about it in advance. Feeling like a zombie and feeling restless or jittery are commonly reported side effects associated with noncompliance. Concerned families should advocate to the doctor assertively on behalf of their relatives for aggressive side effect treatment.

Preventing other noncompliance

- Believe in compliance - About one-third of people with schizophrenia say that they stay on medicine primarily because other people think it's important.
- Prevent relapse - Preventing relapse includes finding the most effective drug, the best dose for the person, and aggressively treating the early signs of relapse.
- Simplify the drug regimen - Complex drug regimens can cause noncompliance. The pharmacist can be a major ally when reviewing and simplifying drug regimens.
- Make transitions seamless - Minimizing the likelihood of noncompliance starts during inpatient treatment. Arrange for outpatient benefits (e.g., Medicaid), an appropriate living situation, and psychiatric aftercare.
- Provide concrete directions and review them with the patient. Foster the therapeutic alliance - Many aspects of the clinical relationship provide consumers with incentives to maintain compliance. Find a doctor or treatment system that works well with families, especially regarding cross-communication and side-effect management. Use hospitalization as a last resort to stabilize the person's acute symptoms and establish a plan for better compliance.
- Recommend depot drug delivery - Converting from an oral to an injectable (depot) form of medication during hospitalization may improve compliance. The family may have to push for this approach.
- Organize the family - Get as many family members as possible to go to educational sessions or meetings so that everyone can present a consistent and coherent message about compliance.

- Try to avoid direct power struggles - In general, it is better to have the treatment system do the "arm twisting."
- Resort to involuntary commitment when necessary - After involuntary commitment, about two-thirds of the patients say that they understand why they had to be committed.

Fraud and Exploitation and How to Avoid Them

Fraud by Friends and Family--new "best friends"; thieving "caregivers"; religious con-artists; financial abuse by family members. This is exploitation and should be reported to Adult Protective Service. Report instances of fraud as described below to the appropriate Attorney General's office in your State or contact your APS office for the appropriate referral.

Home Equity Fraud--Homeowners may be tricked into signing over the deeds to their homes. Often this scam is done by a person pretending to be a repairman or someone offering another service. The elderly person signs a contract believing it to be for roof repair, for example, and does not read it carefully enough to realize that it is a deed to their own home.

How to Avoid Home Equity Fraud--Make sure the contractors you hire are licensed, bonded, and insured; hire only attorneys with malpractice insurance; keep current with property tax bills; sign a grant deed with an attorney present; have a reputable attorney or trusted people examine documents before you sign them; don't use your home as collateral; get several estimates from contractors and check their references; contact the Better Business Bureau; read the fine print; check with your city or bank for home repair financing programs.

Telemarketing Fraud--Some examples of telemarketing schemes which target elders are the "You Are A Winner!" pitch, which misleads victims with a non-existent prize in order to get them to buy something; offers to "get your stolen money back for you"; great loans or "fixing" bad credit; fantastic low prices on merchandise; any caller requesting your bank account or credit card number.

How to Avoid Telemarketing Fraud--If you hear these tip-offs just say NO and hang up!: act now or the offer will expire; you've won a "free" gift, vacation or prize, but you must pay for "postage and handling" or some other charge; you must send money, give a credit or bank card number, or have your check picked up by courier before you can think it over; you can't afford to miss this high-profit, no-risk offer; we can get your money back!; make a decision based on trust; use of high pressure sales tactics when you say no.

Mail Fraud--If it sounds too good to be true, it probably is. Watch for fake contests, prizes, lotteries, chain letters, insurance deals, land and advance-fee selling swindles, franchise and charity schemes, work-at-home and fraudulent diploma schemes, and promotions for fake health cures, beauty devices, and diets.

How to Avoid Mail Fraud--Don't believe you have won any contest until you receive the check, and if you have to pay money or buy something to get the check, it is a scam. For more information contact Postal Service Mail Fraud Complaint Center at 1-800-372-8347 or National Fraud Information Center 1-800-876-7060.

Health Fraud--Some health fraud scams to watch for are advertisements for fake "cures"; fraudulent medical and health services marketed via the television or telephone (victims send in their money and never receive the ordered item or receive a copy rather than an authentic product); "free" hearing tests and hearing aids; health care fraud where phony or real physicians take advantage of patients as a means of getting money from the victim's insurance company; and bogus insurance companies.

How to Avoid Health Fraud--Beware of "free hearing tests" and never agree to a hearing test in your home; shop around before buying; question any "free" medical service or quick or painless cure; avoid special, secret, ancient, or foreign formulas that are only available by mail or from only one supplier.

Money-related Fraud--theft of stocks and bonds that are stored at home; mismanagement of assets by caregivers; real estate rip-offs; ATM "repairman" thefts of cash, ATM cards, or account passwords; check forgery; non-refundable fees for services not delivered.

How to Avoid Money-related Fraud--Avoid or hang up on strangers who want to take your money or know about your finances; say "No!" to anyone who presses you to make an immediate decision; never give anyone a blank check; count your change and check your receipts; don't give your credit card number over the phone unless you have made the call to what you know is a reputable company; be cautious if you don't have experience in handling money. Contact the Women's Financial Information Program of the American Association of Retired Persons for more information at 1-202-434-6030.

Slamming--Your telephone long distance carrier service is changed without your permission. It is illegal.

How to Avoid Slamming--Check your telephone bill carefully every month.

Cramming--Charges are made to your credit card or phone bill which you did not authorize. You don't have to pay for fraudulent charges.

How to Avoid Cramming--Carefully review your telephone bill and credit card bills each month; if you fill out a form to enter a contest or sweepstakes, read the fine print to be sure you are not authorizing changes or charges to your telephone.

Universal Declaration of Human Rights

- All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.
- Everyone is entitled to all the rights and freedoms set forth in this declaration, without discrimination of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.
- Everyone has the right to life, liberty, and security of person.
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- Everyone has the right to recognition everywhere as a person before the law.
- No one shall be subjected to arbitrary arrest, detention, or exile.
- Everyone is entitled to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.
- No one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, nor to attacks upon his honor and reputation.
- Everyone has the right to the protection of the law against such interference or attacks.
- Everyone has the right to own property alone as well as in association with others. No one shall be deprived of his property.
- Everyone has the right to freedom of thought, conscience, opinion, and religion.

(From the United Nations Economic, Social, and Cultural Organization, adopted by the United Nations General Assembly, December 10, 1948.)

Ways You Can Help Tips for Caregivers

A Questionnaire

Providing care for an elderly or disabled adult requires a lot of patience, time, and love. All too often, caregivers run the risk of neglecting themselves, affecting their ability to provide adequate services. The following questionnaire can be used as a guideline by caregivers. If you answer “yes” to one or more of the following questions, you might consider seeking professional help or turning to whatever support system you have developed:

- Are you getting enough rest?
- Are you neglecting your own health?
- Is constant surveillance required as part of your care tasks?
- Have you turned to drugs or alcohol or increased their intake to deal with stress?
- Have your feelings toward the person you are caring for become more negative?
- Is the person you are caring for ever physically or verbally abusive toward you?
- Does the person you are caring for need legal assistance with things like estates, trusts, or living wills, which may be beyond your knowledge?
- Does the person you are caring need to be transported often?
- Are you overwhelmed because you are taking care of more than one person at a time?
- Are financial constraints interfering with your ability to follow medical advice?
- Are problems from your family’s history resurfacing and contributing to the problem?
- Does your spouse resent the amount of time you spend as a caregiver?
- Are you confused, fearful, or angry as a result of being a caregiver?
- Is your family communicating regarding the division of responsibilities?

(Adapted from *Taking Care of Aging Family Members: A Practical Guide* by Wendy Lustbader and Nancy R. Hooyman)

Preventing Exploitation Through Money Management

An estimated 500,000 older people in the United States need help with their financial affairs. As a result, a new field called daily money managers is evolving to provide money management services. Daily money managers organize and keep track of financial and medical insurance records; establish a budget; help with check writing and checkbook balancing; and administer the benefits of people who can't manage their own financial affairs. Private pay money managers typically charge \$25 to \$100 an hour, but some states and communities have free or very affordable money management services for vulnerable adults, particularly those who are low income. Although it is difficult to generalize the total cost, many clients require only a few hours of services each month. Some local governments and community organizations also offer reduced-fee or free services for low income clients.

Do You Know An Elder Who Needs a Daily Money Manager? With the elder's help or permission, review his or her checkbook, bank statements, and canceled checks. Look for things such as payments for medical bills that already have been paid; numerous payments to credit card companies, home shopping networks, sweepstakes or other contests; unusually large charitable donations; failure to track deposits or expenditures; lost checkbooks or bank statements; numerous transfers from savings to checking accounts; or consistent or unusual payments to a questionable recipient. Review bills and correspondence and watch for letters from creditors or past-due notices. The review may indicate that a daily money manager is needed. If your review gives you reason to believe that a caregiver, family member, or friend is improperly using the elder’s resources for their own benefit, report the situation to Adult Protective Services. If you and the elder decide that a daily money manager would be helpful,

interview several candidates. Get references and talk with their clients. Contact the local Better Business Bureau, chamber of commerce, local consumer protection agency, or area agency on aging. Ask if they have any complaints on file, but be aware that no complaints doesn't necessarily mean they have no previous problems. Ask them for their company's financial statement.

For More Information

The Eldercare Locator -- a nationwide, toll-free assistance directory sponsored by the National Association of Area Agencies on Aging will refer you to the area agency on aging nearest to your parent or other older adult. 1-800- 677-1116. Another resource is the American Association of Daily Money Managers, P.O. Box 755, Silver Spring, MD 20918. 1-301-593-5462. The association can provide names of daily money managers in an older person's community or nearby.

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Resource List - Associations and Agencies

Alzheimer's Association
919 North Michigan Avenue, Suite 1100
Chicago, IL 60611-1676
1-800-272-3900
<http://www.alz.org>

AARP
601 E Street, NW
Washington, DC 20049
1-800-424-3410
<http://www.aarp.org>

American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329
1-800-227-2345
<http://www.cancer.org>

American Diabetes Association
1701 North Beauregard Street
Alexandria, VA 22311
1-800-342-23837
<http://www.diabetes.org>

American Foundation for the Blind (AFB)
820 First Street, NE Suite 400
Washington, DC 20036
1-202-408-8170
<http://www.nfb.org>

American Heart Association
7572 Greenville Avenue
Dallas, TX 75231
1-800-AHA-USA1 (1-800-242-8721)
<http://www.americanheart.org>

American Lung Association
1740 Broadway
New York, NY 10019
1-212-315-8700
<http://www.lungusa.org>

American Society on Aging
833 Market Street Suite 511
San Francisco, CA 94103-1824
<http://www.asaging.org>

Arthritis Foundation Information Line
1330 West Peachtree Street
Atlanta, GA 30309
1-800-283-7800 or 1-404-872-7100
<http://www.arthritis.org>

Asthma & Allergy Foundation Hotline
1233 20th Street, NW Suite 402
Washington, DC 20036
1-800-7ASTHMA (1800-727-8462)
<http://www.AAFA.org>

Clearinghouse on Abuse and Neglect of the
Elderly (CANE)
Department of Consumer Studies
University of Delaware
Newark, DE 19716
1-302-831-3523
CANE@udel.edu

Know Fraud
P.O. Box 45600
Washington, D.C. 20026
1-877-987-3728
<http://www.consumer.gov/knowfraud>

Meals on Wheels Association of America
(MOWAA)
1414 Prince Street Suite 202
Alexandria, VA 22314

National Association of Adult Protective Services Administrators

National Center on Elder Abuse

1-703-548-5558

<http://www.mowaa.org>

Medicare Hotline

1-800-638-6833

National AIDS Hotline

1-800-342-AIDS (2437)

1-800-344-SIDA (7432) Spanish

National Association for Continence

1-800-BLADDER (1-800-252-3337)

<http://www.nafc.org>

National Association of Adult Protective
Services Administrators (NAAPSA)

960 Lincoln Place

Boulder, CO 80302

720-565-0906

<http://www.naapsa.org>

National Association of Nutrition and
Aging Services Programs (NANASP)

P.O. Box 9007

Grand Rapids, MI 49509

1-616-531-9909

National Association of Retired and Senior
Volunteer Program Directors, Inc.

(NARSVP)

P.O. Box 852

Athens, AL 35612

1-256-232-7207

<http://www.narsvp.org>

National Association of State Units on
Aging (NASUA)

1201 15th St., NW Suite 350

Washington, D.C. 20005-2800

1-202-898-2578

<http://www.nasua.org>

National Center on Elder Abuse (NCEA)

1201 15th Street, NW Suite 350

Washington, D.C. 20005-2800

1-202-898-2586

<http://elderabusecenter.org>

National Citizens' Coalition for Nursing
Home Reform (NCCNHR)
1424 16th Street NW Suite 202
Washington, DC 20036
1-202-332-2275

National Clearinghouse on Alcohol & Drug
Information Hotline
1-800-729-6686
<http://www.health.org>

National Committee for the Prevention of
Elder Abuse (NCPEA)
c/o Institute on Aging
UMass Memorial Health Care
119 Belmont Street
Worcester, MA. 01605
508-334-6166
www.preventelderabuse.org

National Council on the Aging
409 3rd Street, SW 2nd Floor
Washington, DC 20024
1-202-479-1200
<http://www.ncoa.org>

National Fraud Information Center
P.O. Box 65868
Washington, DC 20035
1-800-876-7060
<http://www.fraud.org>

National Hispanic Council on Aging
2713 Ontario Road, NW Suite 200

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Washington, DC 20009
1-202-745-2521

National Indian Council on Aging, Inc.
(NICA)
10501 Montgomery Boulevard, NE Suite 210
Albuquerque, NM 87111
1-505-292-2001

National Institute on Deafness & Other
Communication Disorders

1 Communication Avenue
Bethesda, MD 20892-3456
1-800-241-1044
<http://www.nih.gov/nidcd>

National Kidney Foundation

30 East 33rd Street
New York, NY 10016
1-800-622-9010
<http://www.kidney.org>

National Mental Health Association

1021 Prince Street
Alexandria, VA 22314
1-800-969-6642
<http://www.nmha.org>

National Stroke Association

9707 East Easter Lane
Englewood, CO 80112
1-800-STROKES (787-6537)
<http://www.stroke.org>

Older Women's League (OWL)

666 11th Street NW Suite 700
Washington, D.C. 20001
1-800-Take Owl (825-3695)
<http://www.owl-national.org>

Recording for the Blind and Dyslexic

1314 West 45th Street
Austin, Texas 78756
1-512-323-9390
<http://www.rfbd.org>

Susan B. Komen Foundation (Breast
Cancer Information)

5005 LBJ Freeway Suite 250
Dallas, TX 75244
1-800-462-9273
<http://www.komen.org>

The Eldercare Locator

National Association of Area Agencies on
Aging

927 15th Street NW 6th Floor
Washington, DC 20005

1-800-677-1116
<http://www.aoa.dhhs.gov>

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3. Elder Abuse Assessment and Reporting

Throughout the past three decades, significant progress has been made in increasing awareness of abusive relationships. Nonetheless, child abuse and domestic violence continue to receive more recognition than elder abuse and more attention in both public and medical settings.

Due to the growing number of older Americans, the number of elder abuse cases will increase. The impact of elder abuse as a public health issue will likely grow in the future. Abuse victims have twice as many physician visits compared with the general US population. This of course allows opportunities for detection. Since many elders are isolated, an unexpected visit to the emergency department may be the only opportunity for detection. Emergency physicians are in a unique position to affect diagnosis and management of this vulnerable population.

Elder abuse encompasses a range of behaviors, events, and circumstances. Elder abuse usually consists of repetitive incidences including any act of commission or omission that result in harm or threatened harm to the health and welfare of an older adult.

The US National Academy of Sciences defines elder abuse as follows:

“Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder. Failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm”.

However, terms may vary among professionals and researchers, and usage is not consistent in the laws of different states. For example, the age at which a person is considered elderly, usually 60 or 65 years, varies. Seven categories of elder abuse have been described by the National Center on Elder Abuse (NCEA) including:

- “Physical abuse - Any act of violence that causes pain, injury, impairment, or disease, including striking, pushing, force-feeding, and improper use of physical restraints or medication
- Emotional or psychological abuse - Conduct that causes mental anguish including threats, verbal or nonverbal insults, isolation, and humiliation. Some legal definitions require identification of at least 10 episodes of this type of behavior within a single year to constitute abuse.
- Financial or material exploitation - Misuse of an elderly person's money or assets for personal gain. Acts such as stealing (money, social security checks, possessions) or coercion (changing a will, assuming power of attorney) constitute financial abuse.

- Neglect - Failure of a caretaker to provide for the patient's basic needs. As in the previous examples of abuse, neglect can be physical, emotional, or financial. Physical neglect is failure to provide eyeglasses or dentures, preventive health care, safety precautions, or hygiene. Emotional neglect includes failure to provide social stimulation (leaving an older person alone for extended periods). Financial neglect involves failure to use the resources available to restore or maintain the well-being of the aging adult.
- Sexual abuse - Nonconsensual intimate contact or exposure or any similar activity when the patient is incapable of giving consent. Family members, friends, institutional employees, and fellow patients can commit sexual abuse.
- Self-neglect - Behavior in which seniors compromise their own health and safety, as when an aging adult refuses needed help with various daily activities. When the patient is deemed competent, many ethical questions arise regarding the patient's right of autonomy and the physician's oath of beneficence.
- Abandonment - The desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.”

(Source: National Center on Elder Abuse (NCEA))

Occurrence

A report from the National Research Council suggests that 1-2 million Americans age 65 years or older have been injured, exploited, or otherwise mistreated. Other studies suggest that 3-10% of elders are abused or neglected. Several variables contribute to the underestimation of abused elders including fear, shame, guilt, and/or lack of information. A variety of professionals underreport elder abuse due to lack of recognition and awareness of reporting requirements. A significant amount of research excludes specific demographics such as persons unable to respond to a survey, speakers of languages other than English, and persons with mental illness. Studies have shown that only 1 in 6 victims are likely to self-report mistreatment to the appropriate legal authorities.

Elder physical abuse victims, caregiver neglect, or self-neglect have triple the mortality of those never abused. Proactive detection and intervention by professionals could potentially lead to decreased mortality. Healthcare provider proactivity is essential.

Race

Elder abuse exists throughout all racial, socioeconomic, and religious backgrounds. The NCEA found the following racial and ethnic distribution among older persons who had been abused:

- White, non-Hispanic – 66.4%
- Black – 18.7%
- Hispanic – 10%
- Other – 4.9%

Gender

Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in

women typically is greater than in men. Numerous studies, however, have found no differences based on sex.

Age

By definition, elder abuse occurs in the elderly, although there is no universally accepted definition of when old age begins. Typically, 60 or 65 years is considered the threshold of old age.

The American Medical Association has recommended that health care professionals regularly ask elderly patients about abuse, even when there are no visible signs/symptoms. There is not yet a consensus on what constitutes an appropriate screen or assessment instrument for detecting elder abuse.

Risk factors of elder abuse include:

- Shared living situation with abuser, likely due to an increased opportunity for contact
- Dementia
- Social isolation
- Pathologic characteristics of perpetrators such as mental illness and alcohol misuse

It would be helpful for providers to consider these "red flags" while providing services for the elderly. The presence of red flags is an indicator that a more in-depth history and/or assessment are necessary. While evaluating a client for possible elder abuse, the provider may want to consider simple and direct questions which are posed in a nonjudgmental or nonthreatening manner. It is also helpful to interview the patient and caregiver both together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate and objective documentation of the interview is important partially because findings may be entered as evidence in criminal trials or in guardianship hearings. Documentation must be complete, thorough, and legible. It is helpful to quote direct statements made by the client.

Physical

In a systematic summary of the published work on forensic markers of elder abuse with respect to physical findings, there is a paucity of primary data.

Most research on clinical findings purported to be common in elder abuse derives from anecdotes, case reports, or small case series. Although not guided strongly by evidence, a number of clinical findings and observations make elder abuse a strong possibility, including the following:

- Several injuries in various stages of evolution
- Unexplained injuries
- Delay in seeking treatment
- Injuries inconsistent with history
- Contradictory explanations given by the patient and caregiver
- Laboratory findings indicating under dosage or over dosage of medications
- Bruises, welts, lacerations, rope marks, burns
- Venereal disease or genital infections
- Dehydration, malnutrition, decubitus ulcers, poor hygiene
- Signs of withdrawal, depression, agitation, or infantile behavior

Causes

Many theories have been developed to explain abusive behavior toward elderly people. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psychosocial and cultural factors are involved.

Theories of the origin of mistreatment of elders have been divided into 4 major categories, as follows: physical and mental impairment of the patient, caregiver stress, trans-generational violence, and psychopathology in the abuser.

- **Physical and mental impairment of the patient**
 - Recent studies have failed to show direct correlation between patient frailty and abuse, even though it had been assumed that frailty itself was a risk factor for abuse.
 - Physical and mental impairment nevertheless appear to play an indirect role in elder abuse, decreasing seniors' ability to defend themselves or to escape, thus increasing vulnerability.
- **Caregiver stress**
 - This theory suggests that elder abuse is caused by the stress associated with caring for an elderly patient, compounded by stresses from the outside world.
 - The effect of stress factors (e.g., alcohol or drug abuse, potential for injury from falls, incontinence, elderly persons' violent verbal behavior, employment problems, low income on the part of the abuser) may all culminate in caregivers' expressions of anger or antagonism toward the elderly person, resulting in violence.
 - This theory, however, does not explain how individuals in identically stressful situations manage without abusing seniors in their care. Stress should be seen more as a trigger for abuse than as a cause.
- **Trans-generational violence:** This theory asserts that family violence is a learned behavior that is passed down from generation to generation. Thus, the child who was once abused by the parent continues the cycle of violence when both are older.
- **Psychopathology in the abuser:** This theory focuses on a psychological deficiency in the development of the abuser. Drug and alcohol addiction, personality disorders, mental retardation, dementia, and other conditions can increase the likelihood of elder abuse. In fact, family members with such conditions are most likely to be primary caretakers for elderly relatives because they are the individuals typically at home due to lack of employment.
- **Other risk factors in abuse** are (1) shared living arrangements between the elder person and the abuser, (2) dependence of the abuser on the victim, and (3) social isolation of the elder person.

A mandated reporter must report a known or suspected instance of elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she (1) has observed or has knowledge of an incident that reasonably appears to be physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; (2) is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; or (3) reasonably suspects abuse.

Optional Reports: Mandated reporters may report a known or suspected instance of elder or dependent adult abuse when they have knowledge of or reasonably suspect that a form of elder or dependent adult abuse for which a report is not mandated has been inflicted upon an elder or dependent adult or that the elder or dependent adult's emotional well-being is threatened in any other way.

- Definition of Elder: An “elder” is a person who is age 65 years or older.
- Definition of Dependent Adult: a dependent adult is a person, between the ages of 18 years and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

Mandated reporters, including therapists, are now required to report the following:

- Known and reasonably suspected physical abuse of an elder or dependent adult.
- Instances of known and reasonably suspected neglect, financial abuse, abandonment, abduction, and/or isolation of an elder or dependent adult, and any other treatment that results in physical harm, pain, or mental suffering.

As a mandated reporter, a psychotherapist is required to make a report of known or suspected elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she has observed or has knowledge of an incident that reasonably appears to be abuse, is told by an elder or dependent adult that he or she has experienced behavior constituting abuse; and/or reasonably suspects abuse.

Abuse of an elder or dependent adult includes the following categories: Physical abuse, neglect, financial abuse, abandonment, abduction, isolation, and any other form of treatment that results in physical harm, pain, or mental suffering. Mental suffering may consist of fear, confusion, severe depression, agitation, or other serious emotional distress caused by threats, harassment, or other forms of intimidating behavior.

Physical Abuse includes assault, assault with a deadly weapon or with force likely to cause great bodily injury; battery; sexual assault, unreasonable physical restraint; prolonged or continual deprivation of water or food; and the use of physical or chemical restraint for punishment, for a period of time beyond that for which the medication was ordered through instructions from a licensed physician or surgeon caring for the elder or dependent adult, and/or for any purpose not authorized by the elder or dependent adult’s physician or surgeon. Neglect refers to the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a similar position would provide. Neglect also includes self-neglect, the negligent failure of an elder or dependent adult to provide a reasonable degree of care to himself or herself.

Specific examples of neglect include the failure to assist in personal hygiene or in the provision of food, clothing, or shelter as well as the failure to provide medical care for physical or mental health needs and the failure to prevent malnutrition or dehydration.

Financial Abuse means concealing, taking, or appropriating an elder or dependent adult's property or money to any wrongful use or with the intent to defraud. Abandonment, desertion or willful abandonment by a person having the care or custody of the elder or dependent adult person under circumstances in which a reasonable person would continue to provide care and custody. Isolation, deliberately preventing an elder or dependent adult from receiving his or her mail or phone calls, false imprisonment; and/or the physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with his or her visitors. Reports of known or reasonably suspected elder or dependent adult abuse must be filed by telephone immediately or as soon as practically possible. A written report must then be sent within two working days.

Reporters should generally make reports to their county's adult protective agency or a local law enforcement agency. There are two exceptions to this, however: First, if the abuse occurred in a state mental health hospital or state developmental center, the report should be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services or to the local law enforcement agency. Second, if the abuse occurred in a long-term care facility (other than a state mental hospital or a state developmental center), reports should be made to the local ombudsman or to the local law enforcement agency. Any person legally required to report elder or dependent adult abuse who knowingly fails to report can be found guilty of a misdemeanor that is punishable by not more than six months in the county jail or a fine not to exceed \$1,000 or both imprisonment and a fine. A therapist who fails to make a timely mandated elder or dependent adult abuse report may also face disciplinary action by their governing board and civil action for damages.

The law provides that no person required making a report of elder or dependent adult abuse shall be criminally or civilly liable for such a report, as long as it cannot be proven that the report was made falsely.

California Reporting Requirements

Each California County has an Adult Protective Services (APS) agency to help elder adults (65 years and older) and dependent adults (18-64 who are disabled), when these adults are unable to meet their own needs, or are victims of abuse, neglect or exploitation. County APS agencies investigate reports of abuse of elders and dependent adults who live in private homes, apartments, hotels or hospitals.

APS staff also provides information and referral to other agencies and educates the public about reporting requirements and responsibilities under the Elder and Dependent Adult Abuse Reporting laws. Cross reporting APS agencies, law enforcement agencies and the Office of the State Long-Term Care Ombudsman (OSLTCO) have the responsibility to cross-report allegations of abuse to the appropriate law enforcement agencies, public agencies, and licensing entities having jurisdiction over these cases. These agencies include:

- The California Department of Health Services (DHCS), Licensing & Certification, handles cases of alleged abuse by a member of a hospital or health clinic. County APS staff evaluates abuse cases and arranges for services such as advocacy, counseling, money management, out-of-home placement, or conservatorship.
- The OSLTCO, which is administered by the California Department of Aging (CDA) has jurisdiction for investigating reports of abuse that occur in nursing homes, residential care facilities for the elderly, adult residential facilities, intermediate care facilities, adult day health care facilities, and adult day programs. Ombudsman investigations are completed by certified staff and volunteers at the local Long-Term Care Ombudsman Programs (LTCOP).
- The California Department of State Hospitals has jurisdiction for investigating reports of alleged abuse at California State Mental Hospitals.
- The California Department of Developmental Services (CDDS) has jurisdiction to investigate reports of alleged abuse that occur at State Developmental Centers.

Where and How to Report in California

If you want to report elder abuse or dependent adult abuse in the community, contact your local county APS Office or look up county specific reporting information here [http://](#)

www.cdss.ca.gov/agedblinddisabled/PG2300.htm. Abuse reports may also be made to your local law enforcement agency.

The following forms are to assist you in filing your report of suspected dependent adult or elder abuse. If you are employed by a financial institution, please complete form SOC 342. All other persons should complete form SOC 341.

Please find the CA form "REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE" here <http://www.dss.cahwnet.gov/cdssweb/entres/forms/English/SOC341.pdf>

Please find the CA Spanish version of form "REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE" here <http://www.cdss.ca.gov/cdssweb/entres/forms/Spanish/SOC341SP.pdf>

Please find the form "REPORT OF SUSPECTED DEPENDENT ADULT/ELDER FINANCIAL ABUSE" here <http://www.dss.cahwnet.gov/cdssweb/entres/forms/English/soc342.pdf>

S.2747 - Elder Protection and Abuse Prevention Act 114th Congress (2015-2016)

Sponsor: Sen. Blumenthal, Richard [D-CT] (Introduced 04/05/2016)
Committees: Senate - Health, Education, Labor, and Pensions
Latest Action: 04/05/2016 Read twice and referred to the Committee on Health, Education, Labor, and Pensions. (All Actions)

Summary: S.2747 — 114th Congress (2015-2016)All Bill Information (Except Text)

Introduced in Senate (04/05/2016)

Elder Protection and Abuse Prevention Act

This bill amends the Older Americans Act of 1965 to direct the Administration on Aging of the Department of Health and Human Services to: (1) ensure that all programs funded under such Act include appropriate training in elder abuse prevention and services addressing elder justice and exploitation; and (2) update periodically the need for such training related to prevention of abuse, neglect, and exploitation (including financial exploitation) of older adults.

The Administration has a duty and function to: (1) establish priority information and assistance services for older individuals; and (2) develop a National Eldercare Locator Service, with a nationwide toll free number.

The Administration shall establish a National Adult Protective Services Resources Center.

Each area plan shall provide that the area agency on aging: (1) increases public awareness of elder abuse and financial exploitation, and removes barriers to elder abuse education, prevention, investigation, and treatment; and (2) reports instances of elder abuse.

The Administration shall make grants to states with approved plans for elder abuse and neglect screening.

A state operating a nutrition project shall encourage distributors of nutrition services to distribute information on diabetes, elder abuse, neglect, financial exploitation, and the annual Medicare wellness exam.

A state, an area agency on aging, a nonprofit organization, or a tribal organization shall use a grant for an older individuals' protection from violence project to replicate successful prevention and training models.

The Administration shall award grants to and contract with eligible organizations for projects to engage volunteers over age 50 in supporting older adults (and their families or caretakers) who have experienced or are at risk of elder abuse.

A state may use funds under the National Family Caregiver Support Program to support the Office of the State Long-Term Care Ombudsman.

4. Domestic Violence Later in Life

Domestic Violence in Later Life: A Guide to the Aging Network for Domestic Violence and Victim Service Programs

As the Baby Boom generation born between 1946 and 1964 ages, it is likely more victims of late life violence and abuse will seek out or be referred to the specialized services provided by domestic violence programs. This potential calls for increased collaboration between aging and domestic violence networks to assure maximum support and safety for victims and survivors of abuse in later life. The national aging network of State Units on Aging, Area Agencies on Aging, Tribal and Native organizations, and direct service providers—especially long term care ombudsman programs, adult protective services, legal services, and information and referral/assistance—has a key role to play in speaking out for older victims. With this Issue Brief we hope to encourage expanded dialogue and connections with allied partners.

The Common Issue: Domestic Violence in Later Life Domestic violence in later life occurs when older individuals are physically, sexually, or emotionally abused, exploited, or neglected by someone [with whom] they have an ongoing relationship. . . . Abusers intentionally use coercive tactics, such as isolation, threats, intimidation, manipulation, and violence to gain and maintain control over the victim. — National Clearinghouse on Abuse in Later Life No matter what the victim's age, abusers' tactics are remarkably similar. Abusers frequently look for someone they can dominate, people believed to be weak, people unlikely or unable to retaliate. With respect specifically to abuse in later life, the aggressors include spouses and former spouses, partners, adult children, extended family, and in some cases caregivers. As victims' advocates know well, abusive behaviors such as punishing, isolating, or depriving are at root about a desire for power and control. Power is used to control where the victim goes, who the victim sees, what the victim can or cannot do; decision-making is curtailed; property and financial resources are exploited. A sense of entitlement often underlies the abusive behavior. The problem of abuse in later life occurs in all communities and affects people of all ethnic, cultural, racial, economic, and religious backgrounds. Although most victims are female, older men can be harmed, too.

Domestic abuse in later life and elder abuse often go hand in hand, and the consequences on lives are very similar. Elder abuse, broadly speaking, includes physical, emotional, sexual abuse, financial exploitation, neglect, self-neglect, and abandonment of older persons — terms

defined by law in state adult protective services (APS) statutes. APS laws in most states address the needs of vulnerable adults over the age of 18 who are living alone or with family and who are at risk of abuse, neglect, or exploitation. The network on aging is charged with the responsibility under federal law to serve as a visible advocate for older Americans age 60 and over.

About the Aging Network

The national aging network, established by Congress under the Older Americans Act (OAA), is composed of 56 State Units on Aging, over 600 Area Agencies on Aging, and thousands of public and private local service providers across the country. The U.S. Administration on Aging, an office within the Department of Health and Human Services, administers most OAA programs at the federal level. The aging network serves as a main gateway to OAA programs and to the many services supported by other federal, state and private sources. As a focal point, the network coordinates access, community long-term care, and supportive services for older Americans and their families. The array of services offered through the aging network varies from state to state and county to county; however, the basic structure of the aging service system is consistent throughout the country. State Units on Aging (SUAs) are agencies of state and territorial governments designated by governors and state legislatures to administer, manage, design and advocate for benefits, programs, and services for the elderly and their families and, in many states, for adults with physical disabilities. In addition to overseeing Older Americans Act-funded programs, SUAs have significant policy, planning and advocacy roles in leveraging other federal, state, local, public, and private funds to support programs on aging. Two-thirds of the SUAs administer their state's Medicaid waiver program (often called a home and community-based service waiver), a program which aims to help people in need of significant daily activity support and health services to receive care at home. In over half the states, the SUA administers adult protective services. Some SUAs are members of state domestic violence councils. Some convene or participate in intergovernmental working groups focused on older victims. Each SUA has a staff member who has been designated the elder abuse contact at the state level. State elder abuse contacts can provide consultation on the development of aging network partnerships and collaborations. To locate the SUA in your state, visit www.nasua.org/SUA_members.cfm. Area Agencies on Aging (AAAs) play a pivotal role in communities across the country in planning and developing services to respond to local needs. The AAAs support a range of services in the community including legal assistance, in-home services, information and referral/assistance, client assessment and care management, senior centers, adult day care services, transportation, caregiver support, congregate meals, meals on wheels, chore and homemaker services, telephone reassurance, and friendly visiting. In some states, AAAs are responsible for the delivery of adult protective services. These services include receiving and investigating reports of elder abuse. Most AAAs conduct elder abuse prevention activities such as public education campaigns, training for mandated reporters and educational conferences. Guardianship and money management programs, supported by AAAs in some areas, are examples of services intended to protect those most at risk of abuse.

The AAA is the principal contact point for domestic violence programs interested in local collaboration. Visit www.n4a.org/aboutaaas.cfm to learn more. Use the National Eldercare Locator 1 800-677-1116 or visit www.eldercare.gov to identify the AAA for your area. The Locator is a national, toll-free telephone referral service connecting callers with state and local agencies on aging and community services.

Aging Network Services at a Glance

The services available through the aging network offering support to victims of late life domestic violence and elder abuse fall under four broad categories:

1. Access services
2. Elder rights
3. Services in the community
4. In-home services

Information and Referral Assistance (I&R/A)

Millions of older people and their families around the country receive assistance each year from a network of more than 3,000 aging I&R/A programs and services. Many state agencies on aging have toll-free 800 aging I&R help lines—and in some areas state and local Long Term Care Ombudsman programs share a common intake line with the aging I&R/A. Individuals can also call the AAA for information on services and resources available locally. Most aging I&R/A databases provide information on a wide variety of critical health and human services.

Increasingly, these databases are readily available to the public online. Find out if the aging I&R/A in your area has information about domestic violence services. If not, request to have local contact information included.

State Health Insurance Counseling and Assistance Programs

The State Health Insurance Counseling and Assistance Program, or SHIP, has trained volunteer counselors in every state and several territories who are available to provide free one on-one help with Medicare questions or problems. To locate a program in your area, visit www.medicare.gov/contacts/static/allStateContacts.asp SHIP services can be especially helpful for late life domestic violence victims—in particular adults with disabilities under age 60 who have experienced problems with Medicare, and those not yet enrolled.

Elder rights/Legal Assistance

Legal services help those who could not otherwise afford an attorney to obtain advice, information, and limited representation in civil law matters such as financial abuse and exploitation, consumer problems, advanced directives, and guardianship. These services are primarily provided by local legal services entities in the community funded by AAAs. At the state level, every SUA has a State Legal Service Developer on staff to coordinate the provision of legal assistance. State and area agencies on aging work to expand legal service availability through coordination with state/local bar committees, the development of pro bono or reduced-fee panels and through coordination with grantees of the Legal Services Corporation. Many states also operate statewide legal hotlines. Older Americans Act-funded legal services are free; however, the demand for services far exceeds the dollars available. To meet the needs in the community, many programs establish case intake priorities. The AAA can provide more information about legal resources for older persons in the area.

The following are examples of possible legal remedies for victims of late life violence or elder abuse:

- Assisting a victim to enter into a new power of attorney arrangement and/or revoke authority of an existing attorney in fact (the individual who holds a power of attorney).
- Terminating the powers of a guardian who has abused his or her role.
- Providing defense for a proposed ward in a guardianship proceeding if an abuser is attempting to gain control without looking out for the ward's best interests.

- Returning title to a victim's name for property, vehicles, certificates of deposit, or bank accounts that were taken by a perpetrator.
- Filing an action to recover property or money wrongfully taken.
- Obtaining a restraining order or injunction to stop a perpetrator.
- Establishing a trust to protect the resources of a victim.
- Changing a will back to a testator's/victim's wishes from the changes made by a perpetrator.
- Appealing a denial of public benefits, Social Security, or disability decision.
- Filing for a name change.
- Filing an order for removal of a perpetrator from a victim's property.

The American Bar Association's Law & Aging Guide can help you and a senior legal services program in your area. You can search by state online at www.abanet.org/aging/statemap.html For a listing of State Legal Services Developers see www.tcsg.org/lisd_01.pdf:
Source: Deanna Clingan-Fisher, "Elder Abuse and the Legal Services Connection," National Center on Elder Abuse Newsletter, Vol. 7, No. 7.

Long Term Care Ombudsman Program

Long term care ombudsmen at both the state and local levels advocate for and protect the rights of residents in nursing and care homes. Ombudsmen investigate and work toward resolution of complaints about care voiced by residents or their family members. Federal law requires all states to have a Long Term Care Ombudsman Program. A contact directory of state ombudsman offices is available on the National Long Term Care Ombudsman Resource Center Web site www.ltombudsman.org⁶

Domestic violence doesn't necessarily stop when a victim enters a nursing, assisted living, or care home. In many instances, the ombudsman can identify and respond to these situations. The ombudsman can also be a resource to a victim of domestic violence who has a family member in a nursing home. Similar to domestic violence intervention, the ombudsman focus is to clarify and carry out the wishes of the resident. All communications between the resident and the Ombudsman are confidential. Ombudsmen and domestic violence programs will likely benefit from joint training to promote greater understanding and collaboration.

Elder Abuse Prevention and Coalitions

Community and state advocates all around the country are working to educate the public and increase understanding about elder abuse. In addition to offering various resources on elder abuse such as brochures, wallet cards with reporting numbers, posters, and service directories, state and area agencies on aging help sponsor and organize multidisciplinary conferences, training, and outreach presentations for community leaders, advocates, allied professionals, and concerned citizens. Aging network agencies also lead, coordinate, and participate in state and local elder abuse coalitions. Membership in these coalitions includes law enforcement; prosecutors; adult protective services; representatives from the health care sector; emergency medical services; and other key partners. Often the coalitions develop community projects to increase understanding and outreach to elder abuse victims. Elder abuse prevention activities are mandated by the Older Americans Act. Domestic violence programs, if not already involved in a state or local elder abuse coalition, are encouraged to inquire about becoming a member. Similarly, to promote collaboration and exchange, invite participation of elder abuse partners in state and local domestic violence task forces and coordinating councils.

Adult Protective Services

Adult protective services are authorized under state law. Support is provided to both older and at-risk vulnerable adults who are in danger of being abused or neglected, or who are unable to protect themselves and have no one to assist them. Services include but are not limited to receiving and investigating reports of abuse, neglect or exploitation, legal advocacy, and providing or arranging for community services such as emergency shelter. Service plans are developed for victims who agree to receive help. If the victim is unable to make decisions because of mental illness or dementia and is at risk of continuing harm, adult protective services may provide emergency services and/or petition the court for the appointment of a guardian advocate. The AAA in some areas of the country is the local provider of adult protective services; in most states, however, the county social service agency is assigned responsibility. Domestic violence programs seeking to improve services for victims of late life violence and abuse are encouraged to coordinate with both sectors. Ideally, opportunities would be offered for advocates in the aging, domestic violence, and adult protective services sectors to participate in joint training so that each better understands the other's mandates, philosophies, challenges, and professional cultures. To learn more, visit the National Center on Elder Abuse Web site www.elderabusecenter.org.

Services in the community

Senior Employment and Volunteer Opportunities

Senior employment services are designed to link mature job seekers 55 and over with job opportunities. Income eligible persons are recruited, trained, and referred to job openings with local employers. Funding for the Senior Community Service Employment Program, or SCSEP, comes from the U.S. Department of Labor. SCSEP is operated by national, state, and local agency sponsors. The ultimate goal is to place mature and older workers in permanent, non-subsidized employment. Volunteer opportunities abound in the aging network. Examples include friendly visiting to shut-ins, volunteer ombudsmen service, home meal delivery, benefits counseling, and senior companion services for developmentally disabled children and adults. SCSEP may be a source of help for older domestic violence victims who need job coaching and a gradual, supportive entry into the world of work. According to AARP, more than one quarter of SCSEP positions are filled by job seekers 55–59. Volunteer opportunities in service to older persons may be particularly important for domestic violence victims who feel isolated and for whom such experience would enhance a sense of independence and selfworth. Volunteer opportunities can be explored through contact with the AAA information and referral/assistance service.

In-Home Supportive and Personal Care Services

A wide range of supporting in home, homemaker, and chore services are available to assist older adults who need help with everyday activities. These services are non-medical and may include such things as light housekeeping, laundry, personal care, shopping and cooking, transportation, friendly visiting and telephone reassurance, respite, repair or yard work, and case management. The AAA provides information and assistance in accessing these services. In-home supportive services help prevent social isolation and may help to reduce the likelihood of elder abuse, neglect, and exploitation by family members.

Senior Centers

There are now thousands of senior community centers around the country. These community gathering places serve a variety of purposes, including functioning as meal sites, screening

clinics, recreational centers, social service agency branch offices, mental health counseling clinics, older worker employment agencies, volunteer coordinating centers, and community meeting halls. Senior centers are key locations for reaching victims, or potential victims, of late life domestic violence. They offer a convenient meeting place for community education and discussion/support groups on domestic violence/elder abuse. They can also be a resource for finding community volunteers. Local senior centers offer different types of programs and services based on population needs and resource availability. For more information, contact your local AAA. Working with the Aging Network As with other human service systems, the national aging network is diverse. At the same time, however, members of the network share a common set of values and a single vision: to protect the inherent dignity, security, and equal rights of all older Americans. The key unifying values are these:

- **Self-determination.** The value of self-determination is based on a belief that all older Americans, including residents of nursing and care homes, are entitled to plan and manage their own daily lives: where they live, how they spend their money, what services they receive, and other important daily decisions. Respect, active listening, and open communication are essential tools for empowering choice and independence. If a person loses decision-making capacity due to dementia or other mental health need, a legal guardian or surrogate decision-maker may be appointed (by the individual or court) to make decisions in his or her behalf.
- **Advocacy.** Uniquely in federal law, Older Americans Act authorizing legislation requires state and area agencies on aging to be "visible and active advocates" for older persons. In their role as "systems advocates" they speak out on policy issues; testify at federal/state/local hearings; and identify unmet needs and gaps in services. In parallel step, elder rights programs such as long-term care ombudsman and legal assistance serve an individual advocacy role, speaking out for those who are without voice. There may be distinctions in how the aging network and the domestic violence programs view their advocacy roles. This may be a fruitful place to start identifying similarities and distinctions. Elder rights. The term "elder rights" reflects the aging network's belief that older people have a right to the many benefits, services, and protections promised in law—not just aging statutes, but statutes covering the population at large. Older persons' needs are often ignored and access to important services denied. By providing stepped-up information about benefits to help cut through red tape, legal representation to solve problems, and protective services for those who are most vulnerable, the aging network plays a key role in promoting elder rights. Typically, the states' elder rights systems focus on the coordination of adult protective, long term care ombudsman, legal assistance services.
- **Community-based long term care.** This term encompasses the effort within the aging network to offer elders with long term care needs health and supportive services in their own homes and community. Homemaker, home-health aide, day care, and personal attendant care are among the services provided. Medicaid waivers fund a large proportion of these services. Caregiver support services (such as respite care) are provided to help families maintain the elder in non institutional settings.
- **Eligibility and fees.** Other than age, there are no eligibility criteria restricting services under the Older Americans Act. Other senior services, especially those funded by special state appropriations and federal Medicaid waivers, may have financial criteria for eligibility, require cost sharing, or be offered on a sliding fee schedule. For many in-home services (home-delivered meals, homemaker and chore services, for example) individual needs assessments establish service priorities. There are waiting lists for many services. Under the Older Americans Act, priority in home and community service delivery is given to those who are determined to be in greatest need.

About the Older Victim: Common Indicators of Domestic Violence in Later Life

New collaborations benefit from dialogue and common understanding. Not surprisingly, the behavioral indicators of late life domestic violence parallel victim/ abuser scenarios found in other forms of domestic violence and are likely well known by domestic violence staff. The chart on the next page, developed by experts in elder abuse, is included here to underline the importance of recognizing potential victim and abuser actions.

Responding to and Working with Older Victims

Ending a relationship is always difficult, particularly when it is a loved one. Most victims of abuse in later life prefer to maintain some type of relationship with their spouse/partner, family member, or caregiver – they simply want the abuse to end. Some older victims will choose to stay with an abuser, often for religious, cultural, generational, or financial reasons. These victims can benefit from support, information, safety planning and strategies to break isolation. Personal values formed by an individual's background, experience, and beliefs also play a role. It is important to respect the victim's values, decisions, and cultural heritage. Some cultural groups may be more willing to report abuse or talk to professionals about family problems than others. Race, culture, or ethnicity may influence body language, eye contact, and expressions of emotion. Generational values are also involved. Many older persons may be uncomfortable talking about personal, private matters with strangers. They may fear younger professionals imposing their own generational values about divorce or women's roles onto them and judging their decisions. Some tips for establishing rapport are:

- **The setting.** Establish comfort. Choose a quiet place and face the person directly. Pay attention to lighting; reduce glare from outside sources.
- **The conversation.** Use respectful and formal terms of address: Mrs., Mr., and so on. Introduce yourself clearly. To help reduce stress, start with a non-threatening topic. Speak calmly and clearly in a normal tone. Avoid jargon.
- **Active listening.** Show from the start that you accept the person and understand. Listen for meaning. Restate, "Let's see if I'm clear about this." Reflect, "This seems to be really difficult for you." Validate, "I appreciate your willingness to talk about such a difficult issue."
- **The plan.** Engage the victim in deciding what the next steps should be. "Let's explore the options." Reinforce steps that have been taken so far. Recognize that decisions may take time. Don't rush. Slow down to give the victim time to sort out what he or she has heard.

Domestic Violence/Aging Network Collaborations

The aging network and domestic violence programs are natural allies in the fight against violence in all its forms. Examples of collaboration include participation on multidisciplinary teams, involvement in coalitions, joint training, joint referral protocols, public education, and policy development. The National Center on Elder Abuse Promising Practices Database www.elderabusecenter.org/default.cfm?p=toolsresources.cfm contains a listing of several projects around the country that provide services in collaboration with domestic violence programs. These projects may serve as examples for aging network staff seeking to form new partnerships.

The Wisconsin Coalition Against Domestic Violence, National Clearinghouse on Abuse in Later Life also has compiled profiles of several elder specific services that are provided by domestic violence programs. A summary can be viewed at www.ncall.us/docs/NCALL_Directory.pdf State and National Resources on Late Life Violence

1. National Domestic Violence Hotline 1-800-799-SAFE (7233) or 1- 800-787-3224 (TTY) www.ndvh.org/ Help is available to callers 24 hours a day, 365 days a year. Assistance is

available in English and Spanish with access to more than 140 languages through interpreter services.

2. Domestic Violence and Sexual Assault State Coalitions work with statewide systems and agencies on behalf of the needs and interests of victims of abuse/assault. Coalitions are membership organizations comprised of local domestic violence and sexual assault agencies and other organizations and individuals dedicated to the elimination of abuse. Most do not provide direct services to victims of abuse. Areas where they can help include: public awareness, professional training, community education, information and referral, resource and materials development, technical assistance, and consultation. Coalitions also monitor state and national legislation and lobby to support the creation of laws that increase victim safety and support and hold perpetrators accountable. A contact directory of state domestic violence coalitions is available on the U.S. Department of Justice, Office of Violence Against Women Web site at www.usdoj.gov/ovw/state.htm. To locate your state sexual assault coalition, seemwww.usdoj.gov/ovw/saresources.htm
3. National Center on Elder Abuse, funded by the U.S. Administration on Aging, is a gateway to a wealth of information on subjects ranging from elder abuse and neglect to financial exploitation, nursing home abuse, and domestic violence in later life. Examples of publications are Domestic Violence: Older Women Can Be Victims Too and Multidisciplinary Elder Abuse Prevention Teams: A New Generation. For more information, call (202) 898-2578, e-mail ncea@nasua.org, or visit the NCEA Web site at www.elderabusecenter.org
4. National Clearinghouse on Abuse in Later Life, a project of the Wisconsin Coalition Against Domestic Violence, has numerous publications and resources concerning older battered women and sexual assault including. Examples include Golden Voices: Support Groups for Older Abused Women and A National Domestic Abuse in Later Life Resource Directory. For more information, call (608) 255- 0539, e-mail wcadv@wcadv.org, or visit the Clearinghouse's Web site
5. American Bar Association Commission on Law and Aging has produced a Resource Packet on Domestic Violence and Sexual Abuse in Later Life with funding from the Office on Violence Against Women at the U.S. Department of Justice. For more information, call (202) 662- 8690 or e-mail abanet@abanet.org, or visit www.abanet.org/aging/resourcepack.pdf
6. Clearinghouse on Abuse and Neglect of the Elderly is the nation's largest computerized collection of scholarly references and other resources relating to elder abuse, neglect, and exploitation. To search for literature, visit the CANE Web site at <http://db.rdns.udel.edu:8080/CANE/index.jsp>. To narrow the search, key in 'domestic violence' or 'older battered women.' For more information, call (302) 831-3525 or e-mail CANE-Ud@udel.edu
7. National Resource Center on Domestic Violence, a project of the Pennsylvania Coalition Against Domestic Violence, provides technical assistance, training and information on domestic violence and related issues. For more information, call 1- 800-537-2238, or visit the Center's Web site at www.vawnet.org/index.php
8. National Coalition Against Domestic Violence is a national organization of grassroots shelter and service programs for battered women. It serves as a national information and referral center on domestic violence. For information, technical support, or referral, call (303) 839-1852, e-mail mainoffice@ncadv.org, or visit the Coalition's Web site at www.ncadv.org/
9. Asian & Pacific Islander Institute on Domestic Violence serves as a forum for, and clearinghouse on information, research, resources, and critical issues about violence against women in Asian and Pacific Islander communities. For more information, call (415) 954-9988, email apidvinstitute@apiahf.org, or visit the Institute's Web site at www.apiahf.org/apidvinstitute/default.htm

10. Sacred Circle, National Resource Center to End Violence Against Native Women provides training, consultation, and technical assistance to Indian Nations, tribal organizations, law enforcement agencies, prosecutors, and courts to address the safety needs of Native women who are battered, raped and stalked. It is a project of Cangleska, Inc., which operates a shelter on the Pine Ridge reservation in southwestern South Dakota. For more information, call (605) 341-2050, e-mail scircle@sacred-circle.com, or visit the Sacred Circle Web site at www.sacred-circle.com/
11. National Latino Alliance for the Elimination of Domestic Violence is part of a national effort to address the domestic violence needs and concerns of under-served populations in Latino communities. For more information, call (800) 342-9908 or 1 -800-342-9908, e-mail inquiry@dvalianza.org, or visit the Alianza Web site at www.dvalianza.org
12. Institute on Domestic Violence in the African American Community is focused on setting an agenda to reduce/eliminate domestic violence in the African American community. For more information, call (612) 624-5357, e-mail nidvaac@che.umn.edu, or visit the DV Institute Web site at www.dvinstitute.org
13. Institute on Aging, San Francisco Elder Abuse Prevention Program has worked with local and national organizations to create several publications on late life domestic violence. Titles include:
14. Domestic Violence and the Elderly: A Cross-Training Curriculum in Elder Abuse and Domestic Violence; Serving the Older Battered Woman: A Conference Planning Guide; and Older Battered Women: Integrating Aging and Domestic Violence Services. For more information, call (715) 750-4188, e-mail, elderabuseprevention@ioaging.org, or visit the IOA Web site at www.ioaging.org/programs/eap/eap.html
15. American College of Obstetricians and Gynecologists, Division of Women's Health Issues has produced a variety of materials about domestic violence and older battered women. For more information, call (202) 863-2487, or visit the ACOG Web site at www.acog.org/departments/dept_web.cfm?recno=17
16. Area Agency on Aging, Region One, Phoenix has produced an educational video, The Dance, available in English and Spanish (Nuestro Baile), depicting the life of an older battered woman. For more information or to order a copy of the video, call (602) 264-2255 or 1-888-783-7500. Or visit the agency's Web site at www.aaaphx.org/main/domesticViolence.asp
17. American Medical Association has developed diagnostic and treatment guidelines for physicians on topics of domestic violence and elder abuse. For more information, call (312) 464-5066, or visit the AMA Web site at www.amaassn.org/ama/pub/category/3242.html
18. Family Violence Prevention Fund has a number of helpful publications on domestic violence. For more information, visit the FVPF Web site at <http://endabuse.org/>

Domestic abuse in later life is a problem that has not received the attention it deserves. The dynamics involved in this type of abuse, including domestic violence and sexual assault, are unique and require a specialized response that needs to be integrated into existing victim assistance approaches and programs. The wide range of professionals who come into contact with older victims need to be educated in order to intervene effectively in the situations of abuse they encounter. Training resources will help to build the capacity of the various professional groups who work with older victims of domestic abuse. These practitioners include victim advocates, criminal justice professionals, health care providers, adult protective services workers, and aging services professionals and volunteers. The training DVD *In Their Own*

Words: Domestic Abuse in Later Life presents five compelling stories of abuse in later life conveyed by the survivors themselves, amplified by interviews with the professionals who worked with them. Additional segments address emergency housing, support groups, and effective advocacy—three critical issues for older victims of abuse. The DVD includes a role-play segment to support an interactive workshop on discerning justifications used to excuse abuse, neglect, and/ or financial exploitation of an older adult. The accompanying training guide offers comprehensive guidance to trainers on using the DVD, including background information on domestic abuse in later life. This training package will fill a significant gap in training resources for a wide range of practitioners who, through their daily professional responsibilities, regularly encounter older victims of domestic abuse. Through the voices of older survivors of abuse, these materials will facilitate important discussions about the dynamics of abuse in later life, barriers to living free from abuse, interventions, and potential collaborations to address the needs of victims.

Target audience description

Interdisciplinary audiences An interdisciplinary audience is composed of a diverse range of professionals, generally from the same community. This group may include representatives from law enforcement, prosecution, the courts, health care, the aging network, APS, elder abuse, domestic abuse and sexual assault programs, and others.

Domestic abuse and sexual assault advocates

Community-based domestic abuse (DA) and sexual assault (SA) advocates generally work in nonprofit organizations that provide a range of services. These may include 24-hour crisis lines; individual, peer, and group counseling; support groups; legal advocacy; support in the medical and legal systems; safety planning; and emergency shelter and transitional living programs. System-based advocates work in a prosecutor's office or within another system. They help victims navigate the legal arena. System-based advocates can also provide information, referrals, and assistance with victim compensation.

Adult Protective services/Elder abuse Workers

APS/elder abuse workers in most states must, as ordered by statute, investigate reports of abuse, neglect, and exploitation. Workers assess their clients' need for services to address current situations and to reduce risk and vulnerability. They provide, arrange, or make referrals for appropriate interventions, including medical, criminal justice, civil, legal, financial, or social services.

Aging network Professionals and Volunteers

The aging network consists of state units and area agencies on aging, tribal and native organizations and service providers, adult care centers, and other organizations that focus on the needs of older adults. Aging network professionals and volunteers organize, coordinate, and provide community-based services and opportunities for older Americans (ages 60+) and their families.

Criminal Justice Professionals

Criminal justice professionals include law enforcement, prosecutors, and court personnel. These professionals respond to crisis and other calls to law enforcement, investigate alleged crimes, gather evidence, interview victims and other witnesses, make arrests, prosecute offenders, and enforce court orders. Criminal justice system-based advocates are often called "victim

advocates” or “victim-witness coordinators.” They work with victims who are involved with the legal system.

Health care Professionals

Health care professionals work in inpatient institutions, outpatient clinics, community-based settings, and individuals’ homes. They provide preventive, acute, therapeutic, and long-term care, treatment, and procedures and services to maintain, diagnose, or treat physical and mental conditions.

Video name

Target audience discussion questions

- **I Can’t Believe I’m Free Pat
- **Power and control 15:17
- **APS/Elder Abuse/dynamics of abuse over a 50-year
- **Aging Network
- **Criminal Justice
- **Impact of abuse on Health Care
- ** the victim and other family members over a 50-year period
- **Charm and manipulation of some abusers
- **It is never too late to make significant life changes, even after age 80
- **I Can Hold My lois
- **DA/SA Advocates
- **Dynamics of abuse
- **Head High
- **Health Care in later life
- **Benefits of support groups for older women
- **Victim resilience
- **I’m Having To Suffer for What He Did miss mary
- **Interdisciplinary
- **DA/SA Advocates
- **APS/Elder Abuse
- **Aging Network
- **Criminal Justice
- **Health Care
- **Sexual assault in later life
- **Multiple forms of abuse in the same case
- **Victim resilience and strength
- **Older adults as powerful witnesses
- **Collaboration
- **Creative, supportive, ongoing advocacy
- **When He Shot Me (Annie)

Topical segments

- **Emergency Housing for Older Victims
- **Support Groups for Older Women
- **Effective Advocacy for Older Victims
- **I’m Not Alone Anymore
- **The Best I Know How To Do
- **Appropriate interventions (Four segments of 3–5 minutes each; total 17:38 minutes)

When choosing which video to use for a specific training event, consider the following:

- Review the case-specific Descriptions and Additional Background and the appropriate discussion questions for the target audience for that case or topical segment.
 - Consider the needs of the target audience and determine key teaching points.
 - After showing a segment, allocate at least 30–45 minutes for the audience to react and discuss the questions presented for each case. The videos have a very strong impact on individuals and you must give audience members sufficient time to process their viewing experience, ask questions, and respond to the discussion questions listed.
 - For a training session of 2 hours or less, consider using only one video.
- Selecting Discussion Questions The discussion questions are designed for interdisciplinary audiences and discipline specific groups. Tabs 4–9 contain targeted questions for the various audiences.
- The questions are not designed to demonstrate that participants have watched the film but rather that they can apply what they have learned from it to help older victims in their communities.
 - The questions flow in a recommended order, although trainers can determine which questions will work best for their target audience and may add extra questions as needed.
 - Prior to the training, review the discussion questions and determine which ones best illustrate the learning points for the training. Plan ahead for the answers that participants might give so you can bring out key learning points if they do not come up naturally during the discussion.

5. Screening and Assessment Tools

Brief Abuse Screening for The Elderly (BASE)

The Project Care Tool Series

A complement of tools and measures were developed, tested and/or validated for the Project Care abuse intervention model, three of which have been adapted by the Elder Abuse Knowledge to Action Project of NICE – the Brief Abuse Screen for the Elderly (BASE – see the remainder of this tool), Caregiver Abuse Screen (CASE), and the Indicators of Abuse (IOA). Collectively these tools were designed to screen, assess and plan intervention in cases of abuse.

The BASE – Brief Abuse Screen for the Elderly

For early intervention to be possible, intake workers must always be alert to the possibility of abuse. They have to make a quick decision on the likelihood of abuse even at first contact. This first contact may be on the phone and may be brief, which is why it is particularly important to have a quick and easy screening method for case identification.

Use of the BASE helps determine answers to questions such as: What kinds of abuse are more common? And, how quickly does intervention need to take place? * The BASE provides a written assessment for the workers who subsequently become involved.

Beyond an initial BASE screening, a second and third screening to confirm or disconfirm the possibility of suspected abuse is most effective when completed immediately following:

A two-to-three hour home assessment interview; and A case conference by a multidisciplinary team Project Care's research findings indicated that the three successive administrations of the BASE help identify and predict cases of abuse; the incidence of abuse was approximately 9 – 14% of the cases screened among incoming health and social service agency clients.

*The urgency of intervention was found to be on average two to three weeks; urgency was defined by examples such as an immediate call to the police, safety precautions organized or an immediate visit was required.

Please respond to every question (as well as you can estimate) concerning all clients 60 years or over who are caregivers (regular helper of any kind) or care-receivers:

1. Is the client an elderly person who has a caregiver?

2. Is the client a caregiver of an elderly person?

3. Do you suspect abuse by a caregiver?

4. Do you suspect abuse by a care-receiver?

5. Do you suspect abuse by someone else?

If any answer except "no, not at all" indicate what kind(s) of abuse(s) is (are) suspected.

If abuse is suspected, how soon do you estimate that intervention is needed?

immediately

within 24 hours

24-72 hours

1 week

2 or more weeks

The Life Events Checklist

(Source: The National Center for PTSD)

Life Events Checklist for DSM-5 (LEC-5)

Description

The Life Events Checklist for DSM-5 (LEC-5) is a self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC-5 assesses exposure to 16 events known to potentially result in PTSD or distress and includes one additional item assessing any other extraordinarily stressful event not captured in the first 16 items.

Changes from previous LEC for DSM-IV

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally; (b) you *witnessed it* happen to someone else; (c) you *learned about it* happening to a close family member or close friend; (d) you were *exposed to it as part of your job* (for example, paramedic, police, military, or other first responder); (e) you're *not sure* if it fits; or (f) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

<i>Event</i>	<i>Happened to me</i>	<i>Witnessed it</i>	<i>Learned about it</i>	<i>Part of my job</i>	<i>Not Sure</i>	<i>Doesn't Apply</i>
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

The LEC was originally developed concurrently with the Clinician-Administered PTSD Scale for DSM-IV (CAPS) to be administered before the CAPS. The LEC demonstrated adequate psychometric properties as a stand-alone assessment of traumatic exposure, particularly when evaluating consistency of events that actually happened to a respondent. The original LEC also

demonstrated convergent validity with measures assessing varying levels of exposure to potentially traumatic events and psychopathology known to relate to traumatic exposure. However, the LEC did not establish that the respondent has experienced an event with sufficient severity to meet DSM-IV criteria for a traumatic exposure (Criterion A1), nor did it assess peritraumatic emotional experiences (Criterion A2).

Changes between the original LEC and LEC-5 are minimal:

Item 15 "Sudden, unexpected death of someone close to you" was changed to "Sudden accidental death" Response category "Part of my job" was added Psychometrics are not currently available for the LEC-5. Given the minimal revisions from the original version of the LEC, few psychometric differences are expected.

Administration

Three formats of the LEC-5 are available:

Standard self-report: to establish if an event occurred

Extended self-report: to establish worst event if more than one event occurred

Interview: to establish if Criterion A is met

Sample Item

Item: Natural disaster (for example, flood, hurricane, tornado, earthquake)

Response: Happened to me; Witnessed it; Learned about it; Part of my job; Not Sure

Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). The Life Events Checklist for DSM-5 (LEC-5). Instrument available from the National Center for PTSD at www.ptsd.va.gov References (LEC for DSM-IV)

Gray, M., Litz, B., Hsu, J., & Lombardo, T. Psychometric properties of the Life Events Checklist. (PDF) Assessment, 11, 330-341. doi: 10.1177/1073191104269954 PILOTS

Elder Abuse Screening Tools for Healthcare Professionals

The National Center on Elder Abuse

A number of instruments and protocols for elder abuse screening have been developed. Most have been created for use in hospitals, clinics, or home care. Although all share similar content and are directed toward assisting with the identification of various forms of elder mistreatment, there are key differences in the focus, format, structure, and type of data gathered by each instrument or protocol. Doctors have been ascribed a key role in elder abuse identification and in awareness promotion because they see their elderly patients, on average, five times per year (Yaffee, 2008). The American Medical Association recommends that all geriatric patients receive elder abuse screening (Burnett et al., 2014) and multiple researchers have recommended screening as a way to help prevent and detect elder abuse. However in 2013, the U.S. Preventive Services Task Force concluded that current evidence is insufficient to assess the balance of the benefits and harms of screening all elderly or vulnerable adults for abuse and neglect (U.S. Preventive Task Force, 2013). Additionally, a universal screening tool does not exist without challenges for screening.

Key Takeaways

- Currently there is no gold standard for elder abuse screening.
- Many screening tools exist, with the majority designed for use by health care providers.

- There are differing opinions on whether screening presents more benefits or harms.
- Additional research is needed.
- A positive screen for elder abuse does not ubiquitously mean that elder abuse is occurring, but does indicate that further information should be gathered.

Identifying elder abuse has been a critical issue both in the community and within health care settings. While most abuse is identified in health care settings, studies have shown that rates of abuse identification by health care providers remain low (Burnett et al., 2014, Cohen, 2011, Yaffe et al., 2010). Recent research suggests that only 1.4% of cases reported to Adult Protective Services come from physicians (National Committee for the Prevention of Elder Abuse & The National Adult Protective Services Association, 2012).

Elder abuse screening instruments are currently held to the same standards as disease screening tests and are determined to be valid if they meet the following criteria: (1) are sensitive (effectively identify individuals with the disease); and (2) are specific (effectively identify individuals who do not have the disease as not having the disease). As with all disease screening tests, the screening process results in the label of “positive” or “negative” but a positive screen does not ubiquitously mean that elder abuse is occurring, but does indicate that further information should be gathered (Caldwell et al., 2013, Burnett et al., 2014).

Screening Tools

At the Elder Mistreatment Symposium convened by the Centers for Medicare and Medicaid Services in 2013, three screening tools (presented in table below) were identified for increased use in practice for the screening of elder mistreatment. These tools were identified for their ability to assess multiple types of abuse, for the specifications of the measure, and for the focus of each tool when combined (McMullen et al., 2014). These tools are intended to be used by trained professionals in healthcare settings.

Elder Abuse Screening Tools:

WITH PSYCHOMETRICS:

- Brief Elder Screen for the Elderly (BASE) (Reis et al.)
- Caregiver Abuse Screen (CASE) (Reis & Namiash)
- Elder Assessment Instrument (EAI) (Fulmer & O'Malley)
- Expanded Indicators of Abuse (E-IOA) (Cohen et al.)
- Geriatrics Mistreatment Scale (GMS) (Giraldo-Rodríguez & Rosas-Carrasco)
- Indicators of Abuse (IOA) (Reis & Nahmiash)
- Older Adult Financial Exploitation Measure (OAFEM) (Conrad et al.)
- Screening Tools and Referral Protocol Stopping Abuse Against Older
- Ohioans: A Guide for Service Providers (Bass et al.)

WITHOUT PSYCHOMETRICS:

- Case Detection Guidelines (Rathbone-McCuan)
- Elder Abuse and Neglect Protocol (Tomita)
- Health, Attitudes towards aging, Living arrangements, and Finances (H.A.L.F.) (Ferguson & Beck)
- Screening Protocols for the Identification of Abuse and Neglect in the Elderly (Johnson)

Settings

Studies of various elder abuse screening tools have been conducted in various health care settings. Basic justifications for screening in certain settings and findings of these studies are presented below. This list is not exhaustive. Other healthcare specialists such as orthopedic surgeons, optometrists, plastic surgeons, and dermatologists may also be effective in screening for elder abuse.

PRIMARY CARE

Elders are seen in primary care settings for common conditions associated with aging. Therefore, primary care settings may provide a valuable opportunity for elder abuse screening. Caldwell et al. examined various tools used in primary care settings, and found two with good internal validity – the OAFEM and EASI. However, they note that external validity is difficult to measure because there is no ‘gold standard’ for comparison (Caldwell et al., 2013).

DENTAL CLINICS

Fulmer and colleagues (2012) studied the feasibility of screening for elder mistreatment in busy clinics, including dental clinics, using an adapted version of the Elder Assessment Instrument (EAI). It was found that screening in dental clinics was feasible and study participants were willing to enroll in the study regardless of the sensitive nature of the survey questions (Fulmer et al., 2012).

HOME HEALTH SETTINGS

Pickering et al. (2016) suggest that professionals working in home healthcare have an advantageous position to identify and report elder abuse and neglect because they directly observe most assessment criteria. Furthermore, this is an important setting for elder abuse assessment as older adults are receiving more services from home healthcare providers. They indicate that the use of a tool such as the QualCare scale – focused on identifying the met and unmet needs of the older adults regardless of the mechanisms causing them – can increase identification and reporting of abuse (Pickering et al., 2016).

EMERGENCY DEPARTMENTS

Emergency departments (EDs) have become critical sites for detection of child abuse but the same has not happened for elder abuse despite its prevalence and the potential value of identifying it in the ED (Rosen et al., 2016). EDs serve an important role when older adults interface with healthcare services, and ED nurses may be able to recognize and identify abuse (Phelan, 2012).

OB/GYN CLINICS

Given that women are at an increased risk for elder abuse, OB/GYNs may play a fundamental role in screening for elder abuse. In a study, Leddy et al. (2014) found that routine screening is not currently being conducted due to time constraints, uncertainty about where to call for help and lack of professional protocols on how to respond to abuse. The study indicated a need for greater education and training for elder abuse screening (Leddy et al., 2014).

LONG-TERM CARE SETTINGS

Long-term care settings including nursing homes and skilled nursing facilities present opportunities for screening and detection of elder abuse. Cohen (2011) indicates studies have found that data on the prevalence of abuse or neglect in long-term care institutions is lacking, in part, due to inadequate procedures for its assessment and identification. While many tools have

been suggested and tested for use in the long-term care setting, they need to be further validated to encompass possible abusive behaviors that may be characteristic of institutions (Cohen et al., 2010).

Potential Benefits and Potential Harms of Screening

Potential Benefits

- Screening is critical for early detection and prevention of elder abuse (Burnett et al., 2014).
- Similar to IPV screening for pregnant women, elder abuse screening does not present any noticeable harm. Even if potential benefits are unclear, they are possible (Dong, 2015).
- An encounter with a professional may be an elder's only chance to change an abusive situation and prevent its continuation or exacerbation (Cohen, 2011).
- Early detection and interventions as a result of screening may help ameliorate or stop elder abuse (Dong, 2015).

Potential Harms

- Screening poses an additional challenge for APS agencies, which are already overwhelmed and under-resourced (O'Brien in Dong, 2015).
- There is a perceived lack of response to screening, detection, and reporting, which may lead to even less reporting by healthcare providers (O'Brien in Dong, 2015).
- Initiatives to promote awareness of elder abuse are encouraging, but fail to meet threshold to justify screening (O'Brien in Dong, 2015).
- Existing tools are problematic because they don't detect common forms of abuse including financial and neglect (O'Brien in Dong, 2015).

Challenges and Future Directions

DESIGNING A SCREENING TOOL

- A simple, brief screening and assessment methodology is needed (Caldwell et al., 2013, Fulmer et al., 2004)
- A criterion standard for the diagnosis or validation of elder abuse is lacking (Fulmer et al., 2004, Yaffe et al., 2008, McMullen et al., 2014, Cohen, 2011)

EVALUATION

- A "gold standard" comparison for establishing the validity of elder abuse screening tools does not exist (Caldwell et al., 2013).
- Good-quality randomized, controlled trials focusing on both screening and interventions are needed (U.S. Preventive Task Force, 2013).

CHALLENGES

- Normal aging changes can mimic signs of elder abuse (Fulmer et al., 2004, Lachs & Rosen, 2016, Cohen, 2011)
- Screening tools that take more than an hour to administer meet with increased resistance which decreases screening quality (Cohen, 2011, Yaffe et al., 2008, Fulmer et al., 2004)
- Differentiating between unintentional and intentional injuries and between illnesses that occurred despite appropriate care or as a result of neglect is also time consuming (Bond et al., 2013, Gibbs, 2014).
- Screening cognitively impaired elders can be challenging because physical findings and diagnostic results may be the only source of information to determine the presence of abuse (Rosen et al., 2016, McMullen et al., 2014).

- Elder victims may be reluctant to disclose evidence of abuse to professionals out of fear, shame, or a sense of hopelessness (Fulmer et al., 2004, Fulmer, 2008, Rosen et al., 2016).

6. Occurrence and Experience of Elder Abuse

EXECUTIVE SUMMARY

(Hall, JE, Karch, DL, Crosby, AE. Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements For Use In Elder Abuse Surveillance, Version 1.0. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016.)

Longstanding divergences in the definitions and data elements used to collect information on Elder Abuse (EA) make it difficult to measure EA nationally, compare the problem across states, counties, and cities, and establish trends and patterns in the occurrence and experience of EA. To help remedy these problems and promote public health surveillance of EA, the Centers for Disease Control and Prevention (CDC) and a diverse group of EA experts collaboratively produced version 1.0 of uniform definitions and recommended core data elements for possible use in standardizing the collection of EA data locally and nationally. Proposed uniform definitions were developed for the following phenomena (and for associated terms or elements that could be sources of confusion or disagreement).

Elder Abuse Circumstances or Consequences (associated concepts) Subcategories in the Core Data Element set include:

- 1) Identifying Information,
- 2) Elder Demographics,
- 3) Elder Situational Data Elements,
- 4) Perpetrator Demographics,
- 5) Perpetrator Situational Data Elements,
- 6) Data Elements for All Abuse Events,
- 7) Physical Abuse Data Elements,
- 8) Sexual Abuse Data Elements,
- 9) Emotional/Psychological Abuse Data Elements,
- 10) Neglect by Caregivers Data Elements, and
- 11) Financial Abuse Data Elements.

The development and use of uniform definitions and recommended core data elements is an important first component of a larger process addressing data collection features that cause important discrepancies, gaps, and limitations in what is known about EA. Their use may move the EA prevention field closer to obtaining robust epidemiologic estimates which may provide a stronger basis for evaluating population level prevention/intervention strategies and setting prevention priorities.

As with the other CDC guidelines for uniform definitions and recommended data elements, this initial release of Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements, Version 1.0 is intended to serve as a starting point. Many definitions, data element descriptions, and coding specifications are new, and field testing is necessary to evaluate them.

Introduction

Older adulthood is often labeled the “Golden Years.” It is a point where many Americans expect to do things that they could not do earlier in life due to factors such as family and occupational commitments or financial constraints. It is a time when many Americans expect to continue growing as individuals by pursuing personal interests, hobbies, or even second careers, as their health permits. At a minimum, most Americans believe that old age should be a time in one’s life that is worry-free, peaceful, and stable, where autonomy is retained as long as possible.

Unfortunately, for persons who experience Elder Abuse (EA),^{ii, iii} old age may be far from “golden.” It can be a sad, stressful time filled with pain, poor health, and poverty. It can involve a life that is disconnected from the activities and relationships that one finds most meaningful. This disconnection also affects life within the communities surrounding such persons by denying them access to these valued older contributors who are important sources of knowledge, expertise, and mentoring.

EA can be prevented or halted. However, preventing EA at the population level requires data that will support effective action. Such data enable the effectiveness of prevention and intervention strategies to be assessed and facilitate decisions regarding strategies that should be implemented or further evaluated. The data also inform decisions on how resources should be allocated to achieve EA prevention and intervention objectives.

Numerous organizations and agencies collect EA-related data that could be used for the previous purposes. Unfortunately, these data have often been collected for EA cases using different case definitions. Moreover, the frequently used data collection instruments, protocols, and systems tend to capture information on persons and incidents that is too often incompatible. Such divergences reflect variations in the legislation, statutes or regulations that provide the criteria used to identify cases, or variations in the goals, philosophies, or scope of specific studies.¹⁻⁸ These divergences have made it difficult to determine the magnitude of EA nationally, to compare the problems across states, counties, and cities, and to establish trends and patterns in the occurrence and experience of EA. Given these conditions and consequences, the creation of uniform definitions and data elements for use in collecting EA data is essential. To promote national level public health surveillance of EA, the Centers for Disease Control and Prevention’s Division of Violence Prevention (CDC/DVP) produced a set of uniform definitions and recommended core data elements. Use of uniform definitions and data elements may move the field focused on EA closer to obtaining robust, accurate and reliable epidemiologic estimates.¹ They may also provide a stronger basis for evaluating the effectiveness of population level strategies for prevention and intervention and for setting prevention priorities and objectives.

Public Health Importance of EA

Several factors make EA an important public health issue. First, the growth rate of the older adult population (persons 65 years old and over) has greatly exceeded the growth rate of the population of the country as a whole. In 1900 there were 3 million older adults, by 1994 there were 33 million, by 2030 the U.S Census Bureau estimates that there will be 71 million. About 1 in 8 Americans were aged 65 years and older in 1994, but about 1 in 5 would be in that age group by the year 2030 (U.S. Bureau of the Census, Jennifer Cheeseman Day, personal communication). These demographic trends indicate that there will be an expanded population potentially at-risk for these forms of violence. Second, the public health impacts of EA may be

far-reaching due to the numerous and varied physical and psychosocial consequences of being exposed to these phenomena. However, few studies have examined the consequences of EA, and even fewer have distinguished the impacts of EA from those linked to normal aging.⁸⁻¹⁰ The most commonly documented physical impacts of EA include: welts, wounds, and injuries (bruises, lacerations, dental problems, head injuries, broken bones, pressure sores); persistent physical pain and soreness; nutrition and hydration issues; sleep disturbances; increased susceptibility to new illnesses (including sexually transmitted diseases); exacerbation of pre-existing health conditions; and increased risks for premature death.¹¹⁻¹⁵ EA is predictive of later disability among persons who initially displayed no disability and is associated with increased rates of emergency department utilization, increased risks for hospitalization, and increased risk for mortality.¹⁶⁻¹⁹ Established psychological impacts of EA include levels of psychological distress, emotional symptoms, and depression higher than those observed among elders who have not experienced these exposures.²⁰⁻²⁶ Potential psychological consequences deserving further study are increased risks (relative to younger population of persons who have experienced abusive or neglectful behaviors) for developing fear / anxiety reactions, and post-traumatic stress syndrome. Lastly, the social consequences of EA may vary from increased social isolation (due to self-withdrawal or perpetrator imposition) to decreased social resources (social identities, supports, roles in key networks) and increased expenditures on services to compensate for resources lost through exploitation and to identify and rehabilitate EA victims.^{11,27} The direct medical costs of injuries caused by EA are estimated to contribute more than \$5.3 billion to the nation's annual health expenditures,^{28,29} while financial abuse by itself costs older Americans over \$2.6 billion dollars annually.^{30,31} Other societal costs may include expenses associated with the prosecution, punishment, and rehabilitation of EA perpetrators. Estimates of such expenses are not currently available.

The Need for Uniform Definitions and Recommended Data Elements

Impediments to Data Comparison and Aggregation / Pooling: Administrative Data

It is difficult to confirm and characterize the true public health burden of EA. This is largely due to the methodological problems that definitional variations introduce into efforts to aggregate, compare, and/or interpret data from different sources. For example, administrative data sources (e.g., Adult Protective Services, Long-Term Care Ombudsman, state long-term care facilities, regulatory, and law enforcement) cannot be readily pooled because they use divergent definitions to define cases and collect data. Research by Daly et al, Joegerst et al., and others (including the CNSTAT of the National Research Council of the National Academies of Science) has firmly established that variations in the state or local statutes from which operational definitions have been derived introduce comparability problems that cannot always be resolved in a meaningful way. Characteristics such as the use of different terms and jargon and behavioral categories that are not conceptually or operationally compatible make efforts such as cross-walking for the purpose of data aggregation very difficult. The previous problems are further compounded by sector and system specific characteristics that vary the depth, breadth, and quality of data elements that are available for comparison. These include intrinsic differences in each data collection system's purpose/objectives, design and infrastructure, or scope of focus and operation. They may also include variations in the activities, processes, and procedures by which relevant data are collected, interpreted, or reported. Such system specific characteristics are responsible for the presence of unique or specialized data elements, variations in data element properties, and differences in the set of data elements comprising the core of data collection efforts.

Impediments to Comparison and Aggregation/Pooling: Survey Research Data

Many discussions regarding data on Elder Abuse focus on problems compiling data from administrative data sources. However, there also has been some consideration of how definitional issues affect potentials for comparing or pooling of estimates from population based studies. Estimate pooling involves producing a common estimate as a function of individual estimates such as those obtained in studies of EA's and prevalence. This methodology could be used to obtain more precise estimates of EA's prevalence if the estimates of different population-based studies could be combined in a statistically valid way.

The impediments to pooling estimates from existing population based studies of EA are numerous and diverse. For one, relevant studies were conducted at different points in time, using samples that are not directly comparable. Although the samples are nationally representative, they capture different cohorts in the national population. This is important because studies conducted at different points in history capture groups of older adults whose risks for abuse may be influenced by different societal conditions and occurrences that could result in differences in the population exposure to risk factors for EA over time. Existing population based studies also differ with regard to the age groups from which data were collected as well as the approaches used for sample generation and data collection (e.g., ages 57-85, 60 and older, ages 65 and older). More importantly, the studies differ with regard to how EA was measured. For example, some studies examine only physical abuse, whereas others examine only psychological abuse. Even the measurement of physical abuse itself varies markedly. Different studies measure different types of physical abuse, and varying numbers of abusive behaviors that may be suffered. Laumann et al., for instance, measured three forms of physical abuse using a single question— “Is there anyone who hits, kicks, slaps, or throws things at you?” In contrast, Acierno et al. measured multiple forms and aspects physical abuse using three questions—“Has anyone ever hit you with their hand or object, slapped you, or threatened you with a weapon?”, “Has anyone ever tried to restrain you by holding you down, tying you up, or locking you in your room or house?”, and “Has anyone ever physically hurt you so that you suffered some degree of injury, including cuts, bruises, or other marks?” Lastly, the measures of abuse themselves also vary in behavioral specificity, with some studies using more general, summary measures asking whether elders experienced any one of several behaviors while other studies use greater numbers of questions to allow individual experiences to be measured separately. Differences in this area produce substantial variation in the degree of measurement overlap across studies and in the validity, sensitivity, and specificity of indicators of abuse.

Definitions Developed by Agencies, Associations, and Institutions

As concerned parties have mobilized to confront Elder Abuse, different but related frames have been constructed to define, understand, and address it. The definitional activities and products of such stakeholders have shaped ideas about what should be considered EA, its constituent elements, dimensions, or types, and the specific populations in which it can occur. A cross-section of prominent definitions on Elder Abuse and related constructs is provided in Table 1. Most were developed, are supported, or are used by groups whose stature is sufficient to influence practices and policies governing various sectors of the field of EA prevention. Others were produced by seminal efforts that have expanded thought about how EA should be conceived and measured. All definitions were thoroughly studied in preparation for the definitions development process described in the following section. They provided important building blocks for the creation of the proposed uniform definitions. Although there are some similarities among the provided definitions (and with our proposed uniform definitions), several

differences are worthy of note. Beyond the most obvious variations in terminology, the definitions vary in their level of abstraction (i.e., cover many phenomena very generally in a highly conceptual manner, very concretely address a few behaviors in a narrow context/situation specific way, or assume a position somewhere between these poles). They also vary in their specificity of behavioral manifestations/indicators and elaboration of definitional elements whose meanings might require clarification to assure uniformity in the interpretation and use of the definitions. For example, definitions in the Older Americans Act (OAA), on the website of the National Center for Elder Abuse (NCEA), and in definitions from the National Research Council (NRC) specify conditions that must be present for EA or a related phenomenon to be present (i.e., mistreatment or abuse). They also specify the full range of persons who may be involved. (i.e., older adults/elders, as a result of actions/inactions by caregivers and trusted individuals). In contrast, the definition of EA that the American Medical Association (AMA) devised during the late 1990s discusses EA more generally. This definition does not state what categories of individuals could be considered perpetrators. The AMA definition presented here also differs from the other definitions because it does not include some aspect of trust or an anchoring to a trust relationship as a necessary element for distinguishing EA from victimization due to the actions of strangers.

A Cross-Section of Prominent Definitions On Elder Abuse and Related Constructs

Older individual: An individual who is 60 years of age or older.

Psychological Abuse: intimidation, or cruel punishment with resulting harm, pain, or mental anguish; or deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.

Neglect: The failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an older individual; or Self-neglect.

Fiduciary Abuse: The fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an older individual for monetary or personal benefit, profit or gain, or that results in depriving an older individual of rightful access to, or use of, benefits, resources, belongings, or assets.

The term “elder abuse” means abuse of an older individual. The term “elder abuse, neglect, and exploitation” means abuse, neglect, and exploitation, of an older individual.

Elder abuse An act or omission which results in harm or threatened harm to the health or welfare of an elderly person. Abuse includes intentional infliction of physical or mental injury; sexual abuse; or withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person by one having the care, custody, or responsibility of an elderly person.

Mistreatment: Intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or failure by a caregiver to satisfy the elder’s basic needs to protect the elder from harm.

All six definition sets focus on older adults. However, the specific category of persons given attention in the OAA are persons age 60 and older while the NRC based definitions focus

squarely on persons defined as vulnerable. The AMA definition arguably has the broadest focus of all the definition sets in its reference to “elderly persons.” Notable differences in the degree and type of information provided about proposed categories/ constituent elements reflect differences in each group’s starting point in the operationalization process. The starting points largely determined the nature and content of the underlying conceptual model and will influence any measurement models subsequently developed. For instance, the OAA definitions start with a model including four interrelated global constructs at the highest order— abuse, neglect, self-neglect, and exploitation. Subtypes of these constructs were developed by narrowing the focus from the universe of experiences with abuse, neglect, and exploitation to only those of persons 60 years of age and older. The behavioral content remains unchanged and is fairly abstract in nature due to its political and legal origins and functions. In contrast, the NRC definitions reflect a model that includes abuse and neglect as forms of mistreatment. It does not, however, distinguish further between abuse and neglect to designate specific behavioral or experiential indicators that can be measured or observed. The rationale for this action is straightforward. The CNSTAT’s underlying goal was to provide a viable frame for EA related research while allowing researchers to define the specific indicators of abuse and neglect in a manner most consistent with the operational definitions present in relevant state and federal laws.

Of the set of definitions, the NCEA’s are by far the most detailed and operationally specific. However, the usefulness of the definitions may be limited by their exclusion of definitions for embedded elements, concepts, and terms that are themselves moderately abstract in nature. Terms such as “impairment,” “non-consensual contact,” “harassment,” and “fiduciary responsibility,” for instance, may be misunderstood or interpreted in a manner that diverges from the organization’s intention when read by persons lacking legal training. This could lead to variations in both clinical judgments and the application of structured frameworks for decision making which may rely on EA definitions to provide parameters for case identification, reporting or investigation.

In sum, each of the presented definitions has its own strengths and weaknesses. In their own way, each definition development effort has advanced the field of EA prevention by incrementally improving the rigor with which EA is conceptualized. They have also helped cultivate data collection and research efforts that are better positioned to capture and distinguish behaviors that should be the foci of systems level prevention efforts. Nevertheless, these definitions cannot be directly and immediately used as a basis for data standardization due to the characteristics highlighted in the previous paragraphs. The effort described in this document is an attempt to capitalize or build on the gains made in previous work to improve EA’s definition and measurement. It incorporates lessons learned in these efforts, integrating the strong points of each definition set and attempting to address their limitations with the goal of making further progress towards developing uniform definitions and data elements that would be utilized by the widest possible variety of groups working to prevent EA.

Rationales for Uniform Definitions and Recommended Core Data Elements for Elder Abuse Surveillance The development and use of uniform definitions and recommended core data elements is an important first component of a larger process a process to improve or standardize the data collection on EA. By developing uniform definitions and recommended core data elements, we create a basis from which data standardization work can be initiated. They provide a viable mechanism for coordinating, harmonizing, and linking diverse sources of EA data. Use of these definitions could increase the comparability and usefulness of

administrative and research data. These definitions can make it possible to more fully describe EA's scope and nature, expand knowledge about its developmental history (by allowing individual's interactions with, movement through, or use of different systems to be tracked), and document the outcomes of persons who have perpetrated or experienced EA and have interacted with specific systems or received specific services.

Participatory Process

CDC facilitated development of the proposed uniform definitions and recommended data elements for EA surveillance via a grounded, participatory process. CDC recruited a panel of scientists and practitioners representing multiple disciplines (e.g., medicine, psychology, epidemiology, sociology, gerontology), various affiliations (e.g., government, academic institutions), and diverse areas of interest (e.g., suicidal behavior, public health surveillance, injury prevention). CDC also established relationships with and sought panel participation from staff from other federal agencies focused on EA prevention. The members of the panel formed by the two groups of collaborators are listed on page 6 of this document. Together, panelists 1) identified concerns associated with defining, applying, and gaining acceptance of uniform definitions; 2) identified implications, costs, and benefits inherent to various approaches to definition; and 3) developed draft uniform definitions and recommended data elements for operationalization. They also worked with CDC to develop descriptors for starter data elements and to distinguish Core data elements essential for EA surveillance from Supplementary data elements recommended for collection as resources permit.

CDC staff summarized the recommendations from meetings of the expert panel and incorporated changes recommended by the panel members. They also 1) created a list of terms for sub-definition, 2) researched definitions for these terms, 3) developed descriptions and criteria for the data elements and 4) produced a document containing all of this information. A draft of this document was sent to the expert panel for a final review and then prepped for peer review based on a last set of panel suggestions. The peer review process was extensive. It involved submission of independent critiques, commentary, and suggestions by the eighteen reviewers listed on page 8 of this document. These peer reviewers were nominated by members of the expert panel. CDC compiled comments and suggestions submitted by each peer reviewer. CDC staff then integrated and reconciled (in cases where opposing perspectives emerged) peer review feedback to produce a next iteration of the draft definitions and data elements document. The document incorporating contributions of both the expert panel and the peer review process was subsequently critiqued a final time in CDC's internal scientific review and clearance process. This clearance process ensures the scientific quality, integrity, and relevance of CDC documents before they are released to the public. The current document, *Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements, Version 1.0*, and the forthcoming document *Elder Abuse Surveillance: Supplementary Data Elements* reflect these developmental processes, their diverse facets, and their assorted contributors.

Purpose and Scope

Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements, Version 1.0, is intended for voluntary use by individuals and organizations interested in gathering surveillance data on EA. The term "surveillance" is used in the public health sense and is defined as the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. This process is explicitly tied to public health action, where

existing knowledge is applied to guide authorities to initiate prevention and control efforts. It provides answers to essential questions including:

1. What is the problem? (Who and how many are being injured and in what ways?)
 2. What is the cause? (What are the risks that contribute to injury?)
 3. What works? (How can we intervene and which interventions best reduce the risks and the harm?)
 4. How do we prevent it? (How do we make the best use of available resources to stop people from being injured or to reduce the harm done? How do we add to our resources if they are insufficient?)
- Public health surveillance is therefore directly linked to the population's monitoring and control needs, especially those relating to sources of injury such as EA.

This document is not meant as a set of mandates, but rather is intended to promote and improve consistency of EA measurement and surveillance. If the recommended data elements can be uniformly recorded and the data made available to numerous users, then better estimates of the incidence and prevalence of EA can be obtained and problems such as data incompatibility and high costs of collecting, linking, and using data can be substantially reduced. Broad categories of developed recommended data elements included Core Data Elements (units of data that should be collected or documented for every case/incident) and Supplementary Data Elements (additional data that can be collected to further describe cases/incidents if resources will allow this). The current document only presents content for Core Data Elements. The elements included in this set represent the minimum amount of information needed to establish or evaluate priorities and strategies for EA prevention and intervention. To promote nation-wide interoperability Core Data Elements also include data elements that are critical for record linkage purposes, duplicate record identification/removal, and case monitoring. The recommended data elements are designed to collect information of value for public health surveillance of EA and to serve as a technical reference for automation of the surveillance data.

A structured format, modified slightly from Data Elements or Emergency Department Systems (DEEDS), Release 1.0(National Center for Injury Prevention and Control), is used to document each data element as follows:

- Description/Definition of the data element;
- Description of its Uses;
- Discussion of conceptual or operational issues;
- Specification of the Data Type(and maximum allowed Field Length);
- Indication of when data element Repetition may be necessary to include all answers that may apply;
- Field values/ coding instructions that designate recommended coding specification and valid data entries; and
- Where applicable, reference to one or more Data Standards or Guidelines used to define the data element and its field values, and Other References considered in developing the data element. Data types and field lengths conform to specifications in Health Level7 (HL7), a widely used protocol for electronic data exchange (HL7), and ASTM's Introduction 5(formerly known as the American Society for Testing and Materials) E1238-94: Standard Specification for Transferring Clinical Observations Between Independent Computer Systems (ASTM).

Notes on the Use of Elder Abuse Surveillance Uniform Definitions and Recommended Core Data Elements

The Uniform Definitions are used throughout the Recommended Core Data Elements. The definitions are likely to be of value to policymakers, researchers, public health practitioners,

victim advocates, service providers, and media professionals seeking to clarify discussions about EA. However, most terms in the “Uniform Definitions” are defined in only a comprehensive sense, and practitioners, researchers, and other users may need to further refine and systematically adapt them for use in particular professional and practice settings. Such work should ideally occur within a guided adaptation process that will preserve the core elements of the Uniform Definitions while achieving relevance, sustainability, and acceptability among specific end-user populations. Other terms were not defined by the expert panel and may need to be defined in subsequent versions of the “Uniform Definitions.” Examples of specific issues needing further clarification include how to identify victims and perpetrators in episodes that appear to be mutually violent, and how to capture important developments such as transitions out of victimization or perpetration status.

Next Steps

This initial release of Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements, Version 1.0 is intended to serve as a starting point for advancing surveillance, research, and practice aimed at preventing EA. It is our hope that the proposed Uniform Definitions will assist the field in 1) further describing and delineating the core constituent elements of EA; 2) improving the classification of its behavioral manifestations and its differentiation from other, similar phenomena; 3) clarifying and explaining the practical relevance of concepts, terms, or expressions that are often esoteric and abstract; and 4) making information and vocabulary regarding EA accessible to and actionable for the widest variety of stakeholders. Through such contributions the current effort and any ensuing work will build upon and extend the achievements of earlier definitional efforts.

The developed Supplementary Data Elements will be presented in the forthcoming CDC publication Elder Abuse Surveillance: Supplementary Data Elements. The Supplementary Data Elements presented in this companion publication are designed to augment information provided by the Core Data Elements presented here. The publication will provide practice based and research informed guidance regarding additional administrative, clinical, or survey data that would be beneficial to collect if resources allow. Such data could provide practitioners and researchers with more extensive opportunities for expanded surveillance, etiologic study, and research to inform practice. Many of the Recommended Core Data Element definitions and coding specifications are new, and field testing is necessary to evaluate them. Systematic field studies are needed to gauge the usefulness of Version 1.0 for EA surveillance, to identify optimal methods of data collection, and to specify resource requirements for implementation. Prospective users of Version 1.0 are invited to contact CDC to discuss their plans for evaluating or using some or all of the Uniform Definitions and Recommended Core Data Elements. Lessons learned through field use and evaluation will be a valuable source of input for subsequent revisions, but all comments and suggestions for improving this document are welcome.

UNIFORM DEFINITIONS AND RECOMMENDED CORE DATA ELEMENTS

UNIFORM DEFINITIONS

ELDER ABUSE

An intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.

Sub-definitions:

Intentional / Intentionally Intended or planned; done deliberately, knowingly, willfully, or voluntarily. The term “intentional” limits EA to acts purposefully, deliberately, and consciously taken by another or others. Consistent with other World Health Organization and CDC work on interpersonal violence, intentionality is tied to actions taken regardless of the possible or actual outcomes of the action. In other words, actions should be classified not on the consequences of the act, but on the nature of/motives for the act itself. This classification approach is important. The harm or injuries produced intentionally and unintentionally may be nearly indistinguishable. However, the approaches required to prevent or halt processes leading to intentional injuries and to limit their adverse effects may be wholly different from those needed to address processes that may lead to unintentional injuries. Determining and understanding intent is an indispensable prerequisite for the design of prevention and intervention strategies that are appropriate and effective.

It is acknowledged that (1) acts by caregivers and others in relationships involving expectations of trust may be deliberate and intentional; however, harm to an older adult might not be the intended consequence; (2) harm to an older adult may not be the intended consequence of a failure to act; (3) individual incidents may involve mixtures of intentional and unintentional acts; (4) determining intent is often difficult and in many cases depends on the amount and quality of available evidence, how such evidence is interpreted, and perceptions regarding intent and motives.

Expectation of Trust

The rational expectation or belief that a relative, friend, caregiver, or other person with whom a legally defined professional relationship exists can or should be relied upon to protect the interests of an older adult and/or provide for an older adult’s care. This expectation is based on either the willful assumption of responsibility or expectations of care or protection arising from legal or social conventions. The expectation that the aforementioned persons will perform actions that benefit the older adult, regardless of whether the behaviors are controlled or monitored, creates a condition of vulnerability. Persons such as estranged relatives with whom there is neither affection nor trust would be excluded. In addition, the expectation of trust generally does not extend to strangers or persons of casual acquaintance. The exception is when strangers or casual acquaintances are embraced by older adults as family members, friends, or caregivers. With this transition the former strangers/acquaintances become subject to the same expectations governing the behaviors of others in a position of trust.

Risk

The possibility that an individual will experience an event, illness, condition, disease, disorder, injury or other outcome that is adverse or detrimental and undesirable.

Harm

Immediate or delayed disruptions to an individual’s physical, cognitive, emotional, social, or financial health.

1. Disruption of physical health includes, but is not limited to physical injuries, preventable illnesses, and inadequate nutrition. Physical injuries are physical disruptions, including those that may result in death, occurring to the body due to exposure to thermal, mechanical, electrical, or chemical energy interacting with the body in amounts or rates that exceed the threshold of physiological tolerance, or from the absence of such essentials as oxygen or heat.

Physical injuries can include physical marks, burns, lacerations, contusions, abrasions, broken bones, internal injuries, organ damage, poisoning, asphyxiation.

Preventable illnesses are those illnesses and diseases that can be avoided by initiating preventive health behaviors or using preventive health care services. Examples include pneumococcal diseases, influenza, and tetanus. Preventable illnesses can increase morbidity and mortality among older adults because, relative to younger populations, older adults, on average, tend to experience more co-occurring medical conditions, may be more susceptible to serious conditions associated with preventable illnesses, and are at higher risk for complications. They may result from a denial of medical care, withholding of medication, or failure to immunize medically vulnerable or frail older adults against diseases.

By itself failure to assure that an older adult is vaccinated is not considered abuse. However, this failure can be interpreted as an element of neglect when combined with other negligent behaviors. While this action alone could not be considered sufficient evidence of neglect, it is often observed in combination with other conditions such as malnutrition, wasting, etc. This is an issue of particular relevance to older adults who are medically vulnerable or frail. Their compromised health states make it extremely vital that steps be taken to avoid preventable illnesses which could spiral into significant, life-threatening conditions.

Inadequate nutrition refers to imbalances in needed nutrients and energy from food that may increase an older adult's risks for adverse health outcomes, poor health, and impaired functioning.

2. Disruption of cognitive health may include changes in cognitive performance (e.g., impaired decision making and problem solving, poor memory performance, and stress-related cognitive interference) or changes in the brain's structural or functional integrity.

3. Disruption of emotional health may involve problems with emotional regulation (the ability to determine what emotions one has, when one has them, and how often one experiences or expresses emotions) or emotional intelligence (the ability to perceive and express emotions, understand affect-laden information, use emotional knowledge, and regulate conditions to foster intellectual growth and well-being).

4. Disruptions of social health may include damaged or severed social bonds, relationships, or social ties, loss of social identities, social positions and social roles, or loss of access to vital social resources, networks, and institutions.

5. Disruptions of financial health or standing may include accrual of new liabilities (e.g., health care costs, loans, credit lines, overdraft or interest fees), net income reductions or potential earnings losses, losses of tangible personal property (e.g., automobiles, houses, art/antiques etc.) reduced or depleted assets (e.g., savings, checking or investment accounts), or reduced availability of funds to cover obligatory (e.g., living expenses, loans or mortgages, medications and required medical care or services) and discretionary (hobbies, leisure, and entertainment) expenses. Such changes may limit or remove options for ensuring satisfaction of one's physiological, psychological and social needs.

INVOLVED PARTIES

Older Adult / Elder

Any person whose chronological age is 60 years or older. Age 60 was selected as the lower boundary for classification as an older adult because it is the age of first eligibility for services furnished under the Older American's Act and for inclusion in activities and programs covered in the Elder Justice Act.

Victim

Person on whom the abuse is inflicted or who experiences abuse. Survivor is often used as a synonym for victim.

Perpetrator / Offender

Person or persons who inflicts or causes the victim to experience abuse. Such persons must be in a relationship involving an expectation of trust.

Current or Former Legal Spouse

Someone to whom the victim is or was legally married, as well as a separated legal spouse.

Other Intimate Partner

Current common-law spouses, current boyfriends/girlfriends/partners (opposite or same sex), former common-law spouses, or former boyfriends/girlfriends/partners (opposite or same sex). Intimate partners may or may not be cohabiting. Intimate partners may or may not have an existing sexual relationship. States differ as to what constitutes a common-law marriage. Users of the Recommended Core Data Elements will need to know what qualifies as a common law marriage in their state.

Child: A person's biological or legally adopted offspring, including a son or daughter. May also include step children and foster children.

Other Family Member/Relative: Someone sharing a relationship by blood or marriage, or other legal contract or arrangement (i.e., legal adoption, foster parenting). This includes current as well as former family relationships. Therefore, though not an exhaustive list, stepparents, parents, siblings, grandchildren, former in-laws, and adopted family members are included in this category. This category excludes the victim's children.

Caregiver

1. Family (Informal) Caregiver: any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of Instrumental Activities of Daily Living (ADL) /Activities of Daily Living(ADL) (defined below) assistance for an older adult. These individuals may be primary or secondary caregivers (i.e., persons who assist a primary caregiver) and live with, or separately from, the person receiving care.
2. Formal Caregiver: a provider associated with a formal service system, whether a paid worker or a volunteer.

Care Custodian

An individual entrusted with the care and maintenance of another person.

Legal Guardian

A person who has been appointed by a court to possess the power and obligation to take care of and manage the property, well-being and/or rights of a person who, because of status as a minor, understanding, or self-control, is considered incapable of administering his or her own affairs.

Other Person in Position of Power or Trust

Someone such as a religious leader, advisor, or employer (not an exhaustive list).

Friend

Someone with whom the victim shares a substantial personal relationship but who is not related to the victim by blood or marriage, and is not a current or former spouse, another current or former intimate partner, another family member, or a person in an official position of power or trust.

Acquaintance / Persons of Casual Acquaintance

Someone who is known casually to or recognized by the victim, with whom no substantial personal relationship exists, who is not related to the victim by blood or marriage, and is not a current or former spouse, another current or former intimate partner, another family member, a friend, a person in an official position of power or trust, or a stranger.

Stranger

Someone who is not known to the victim and with whom no substantial personal, pre-existing relationship exists.

PHYSICAL ABUSE

The intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death.* Physical abuse may include but is not limited to such acts of violence as striking (with or without an object or weapon), hitting, beating, scratching, biting, choking, suffocation, pushing, shoving, shaking, slapping, kicking, stomping, pinching, and burning. In addition, inappropriate use of medications and physical restraints, pinning in place, arm twisting, hair pulling, force-feeding, and physical punishment of any kind also are examples of physical abuse.

* The threat of force with or without a weapon should be considered emotional abuse.

Sub-definitions:**Illness**

An acute or chronic condition of poor health that may affect the body or mind.

Bodily / Physical Injury

Any physical damage or hurt occurring to the body.

Physical Pain

A state of physical uneasiness that ranges from mild discomfort or dull distress to acute, often unbearable, agony. May be generalized or confined to a specific area of the body; is typically the consequence of being injured or hurt physically or as a result of illness. Pain characteristics include the site (localization), onset and offset, character, radiation, associated symptoms, time pattern, exacerbating and ameliorating factors, and severity. Usually produces a reaction of wanting to avoid, escape, yield to, or eliminate the causative factor and its effects.

Functional Impairment

The inability to perform routine and age-appropriate tasks in the domains of work, home, and social activities, as indicated by threshold tests.

Distress

Mental or physical suffering or anguish of the body and/or mind.

Inappropriate Use of Medications

Use of medications in a way that causes bodily injury, physical pain, functional impairment, extreme distress, or death. May involve the use of prescribed drugs as well as those for which a prescription has not been provided. Examples include but are not limited to: administration of medication for the correct indication but at doses that are too high or too low; over-medication, especially over-sedation; under-medication, especially analgesia; administration of the wrong medication; administration of medication for a purpose for which it was not intended; bartering or exchange of medications for coercive purposes.

Inappropriate Use of Physical Restraints

Physical restraints include any device, material or equipment attached to or near a person's body, which cannot be controlled or easily removed by the person. Such restraints deliberately prevent or are deliberately intended to prevent a person's free body movement to a position of choice and/or a person's normal access to their body. The inappropriate use of physical restraints refers to use of such devices, materials, or equipment in a way that causes bodily injury, physical pain, functional impairment, extreme distress, or death or for purpose of punishment. Does not include situations where restraint use has been medically authorized for a legitimate purpose (e.g., managing behavioral aggression associated with acute or chronic psychiatric conditions) and harm is caused by a person's own behaviors or status.

Physical Punishment

The direct or indirect infliction of physical discomfort or pain for the purpose of (1) stopping unwanted behavior, (2) preventing the recurrence of unwanted behavior, or (3) because of a failure to perform a required, requested, or desired activity.

SEXUAL ABUSE

Forced and/or unwanted sexual interaction (touching and non-touching acts) of any kind with an older adult. This may include but is not limited to forced and/or unwanted completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; forced and/or unwanted contact between the mouth and the penis, vulva, or anus; forced and/or unwanted penetration of the anal or genital opening of another person by a hand, finger, or other object; forced and/or unwanted intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; unwarranted, intrusive, and/or painful procedures in caring for genitals or rectal area; or forced and/or unwanted non-contact acts of a sexual nature such as forcing a victim to view pornographic materials, photographing an elder for sexual gratification, voyeurism and verbal or behavioral sexual harassment.

All the above acts also qualify as sexual abuse if they are committed against an incapacitated person who is not competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.

Sub-definitions:**Forced**

Obtained through the use of physical power or the use of express or implied threats of violence, reprisal or other intimidating behavior that puts a person in immediate fear of the consequences in order to compel that person to act against his or her will.

Unwanted

Not wanted, desired, requested, or consented to.

Sexual Interaction

Any of numerous ways by which people experience and express themselves as sexual beings, as influenced and defined by personal preferences and/or social or cultural conventions (religious or legal, according to federal, state, or local law).

Contact Acts

Sexual acts wherein a person physically touches or connects with another person's body using his or her appendages, other body parts, or physical objects.

Non-contact Acts

Sexual acts that do not involve physical contact such as forcing a victim to view pornographic materials, photographing an elder for sexual gratification, voyeurism and verbal or behavioral sexual harassment.

Voyeurism

Deriving sexual satisfaction by secretly watching others undress or engage in sexual activity. May also involve watching to derive satisfaction from another's distress, discomfort, or anxiety.

Sexual Harassment

Any form of unwanted sexual attention (e.g., sexual advances, suggestions, requests or threats) that is deemed inappropriate, offensive, intimidating or humiliating. Harassment includes contact and non-contact acts as defined above.

Incapacitated Person

An individual who is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance. Incapacitation may be isolated in nature involving a single acute experience, intermittent in nature occurring unpredictably or at irregular intervals, or ever-present affecting a person's life on a daily basis. Sources of incapacitation may include but not be limited to illnesses, diseases, or injuries (including those that may become more prevalent or more severe as one ages), mental or physical disability, being asleep or unconscious (e.g., due to the effects of medications), or intoxication (e.g., incapacitation, lack of consciousness, or lack of awareness) through the voluntary or involuntary use of alcohol or drugs.

Competence (mental and legal)

The ability to understand the nature and effect of the act in which an individual is engaged. An individual's status where competence is concerned is jointly influenced by their own characteristics as a decision maker (e.g., intelligence, age, education, health status) as well as the characteristics of the task (e.g., the complexity, familiarity, or clarity of framing) and

the setting, circumstances, or context of decision making (e.g., stress or pressure level, relationship dynamics such as the distribution of power among participants in the interaction).

EMOTIONAL / PSYCHOLOGICAL ABUSE

Verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress, that is perpetrated by a caregiver or other person who stands in a trust relationship to the elder. Such behaviors may have immediate effects or delayed effects that are short or long-term in nature that may or may not be readily apparent to or acknowledged by the victim. May include any of the following and vary according to cultural norms:

1. Humiliation/Disrespect

– Behaviors intended to be, or clearly perceived to be humiliating, degrading, insulting or devaluing the older person. Examples: verbal insults, insults in public, infantilizing comments, calling the older adult stupid, worthless, foolish, etc.

2. Threats

– Verbal or non-verbal gestures or suggestions of intended physical, sexual, or psychological mistreatment; neglect; abandonment; or financial exploitation with the intent of changing or manipulating the behavior of the older person in response. Communication of plans to take a harmful action against the older adult if he or she will not perform desired activities or behaviors, including, for example, plans to leave and never return, claiming that one will stop provision of care, plans of institutionalization or homelessness; threatening to harm other family members, friends or pets or to damage prized possessions; plans to use force with or without a weapon.

3. Harassment

– Behaviors that are repeated in such a manner as to be intended or perceived as hostile, coercing, or manipulating the elder adult to do or not do something against their will. Examples: repeatedly following, watching, or tracking an older adult and doing so in a manner that lets the person know that this is occurring; repeated unwanted telephone calls, letters, or other communications that are hostile or coercive; showing up uninvited at places frequented by an older adult.

4. Isolation/Coercive Control

– Verbal or physical behaviors resulting in either geographic or interpersonal isolation of the older adult. Examples: silent treatment; restriction of phone or car use; intentional seclusion of older adult from family, friends, or other social outlets; relocation to a remote location; withholding assistive devices like a walker, wheel chair, hearing aide, etc; or locking an older adult in a room. All of these behaviors have the effect of disconnecting the older adult from others. Behaviors can also involve ignoring the elder's attempts and needs to interact.

Sub-definitions:

Fear

An unpleasant often strong emotion caused by anticipation or awareness of danger

Infantilize The act of treating an adult as if he or she were an infant or young child

NEGLECT

Failure by a caregiver or other person in a trust relationship to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms.

Sub-definitions:**Failure to meet needs for:**

- Essential medical care Failure to provide for or seek proper medical and/or dental care that affects adversely, or might affect adversely the physical, mental and/or psychological well-being of the older adult.
- Nutrition: Failure to provide, assure, or seek adequate food intake, failure to provide or make food choices that promote health/avoid nutritional deficiencies
- Hydration: Failure to provide, assure, or seek sufficient fluid intake or adequate water consumption.
- Hygiene: Failure to provide or to engage in: regular baths/showers; normal grooming practices such as caring for one's skin, hair, teeth, or nails; proper disposal of urine, feces, and other bodily waste. (Must account for normative standards for hygiene set by specific communities and/or subcultures)
- Clothing: Failure to provide or wear adequate or proper clothing suitable for the weather, cleanliness, or custom and culture of the area.
- Shelter: Failure to provide or maintain a living environment which is safe; free of overcrowding, unsanitary conditions, and structural hazards; and provides proper protection against the elements. (Must account for normative standards for appropriate shelter set by specific communities and/or subcultures)

FINANCIAL ABUSE / EXPLOITATION

The illegal, unauthorized, or improper use of an older individual's resources by a caregiver or other person in a trusting relationship, for the benefit of someone other than the older individual. This includes, but is not limited to, depriving an older individual of rightful access to, information about, or use of personal benefits, resources, belongings, or assets. Examples include but are not limited to: Taking money or items from an older adult's home or accounts without proper authority or approval; occupying, selling, or transferring property against an older adult's wishes or best interests; unauthorized credit or debit card use; opening credit accounts in an older adult's name using their good credit or using an elder's personal information to obtain services (telephone, cable, basic utilities etc.), rent, lease, or buy properties(identity theft); cashing checks without permission or authorization; use of insurance information to obtain medical services; creating or changing insurance policies to benefit another; changing wills, trusts, or inheritance arrangements for another's benefit without an older adult's knowledge or permission; forgery; forcing an older adult to sign a document; abusing joint signature authority on a bank account; misappropriation of funds from a pension; getting an older adult to sign a deed, will, contract, or power of attorney through deception, coercion, or undue influence; using a power of attorney, including a durable power of attorney, for purposes beyond those for which it was originally executed; taking advantage of an elder's lack of capacity to initiate financial transactions, instruments, or documents; improperly using the authority provided by a conservatorship (or guardianship), trust, etc.; negligently mishandling assets, including misuse by a fiduciary or caregiver; denying elder persons access to their money or preventing them from controlling their assets; withholding care for financial gain (e.g. preventing funds to be used for needed care by someone who stands to inherit).

Sub-definitions:**Fraud**

Deception carried out for the purpose of achieving personal gain while causing injury to another party. An intentional distortion of truth initiated to convince another to part with something of value or to surrender a legal right.

Misappropriation

The intentional, illegal use of the property or funds of another person for one's own use or other unauthorized purpose, particularly by any person with a responsibility to care for and protect another's assets (a fiduciary duty).

Power of Attorney

A written document in which one person (the principal) appoints another person to act as an agent on his or her behalf, thus conferring authority on the agent to perform certain acts or functions on behalf of the principal. The certain acts may include signing papers, checks, title documents, contracts, handling bank accounts and other activities in the name of the person granting the power.

Undue Influence

Use of one's role and power to exploit the trust, dependency, and fear of another. The exploiter's role and power are used in ways that deceive or mislead to gain control over the decision making of the person being exploited.

Conservatorship

A conservatorship is created by the appointment of a conservator, also sometimes called a guardian. A conservator or guardian is a person or entity appointed by a court to manage the property, daily affairs, health, and/or financial affairs of another person (called the conservatee or ward), usually someone who is legally incapacitated.

Trust

An entity created to hold assets for the benefit of certain persons or entities, with a trustee managing the trust (and often holding title on behalf of the trust).

Fiduciary

A person (or a business like a bank or stock brokerage) who has the power and obligation to act for another (often called the beneficiary) under circumstances which require total trust, good faith and honesty.

Fiduciary Duty

A duty to act for someone else's benefit, while subordinating one's personal interests to that of the other person. It is the highest standard of duty implied by law (e.g. trustee, guardian).

OTHER RELATED PHENOMENA

While this document focuses on five types of EA, other related phenomena are defined in the literature and state EA statutes. These include abandonment, abduction, medical abuse, resident-to-resident abuse/aggression, and the broad category of rights violations. Examples of definitions for these phenomena are presented below. There is a fair degree of agreement in the EA field about what constitutes abandonment. Abandonment is included in this section because opinions diverge sharply on the issue as to whether it is a subtype of neglect or a wholly separate phenomenon. This is also the case for medical abuse; while some argue that it is a subtype of physical abuse, others emphasize its overlap with neglect, and still others assert that it be addressed as a distinct problem. In producing the content for this document, the expert panel embraced the first and second arguments and determined that the behaviors of medical abuse could be captured by the combination of the proposed EA types and definitions.

Subsequent editions of this document should evaluate shifts in perspectives about this and other related phenomena and reconsider the classifications assigned here.

In contrast, there is considerably less consensus about either the scope of definitions for the remaining phenomena or their relationship to EA. Abduction is one example where numerous definitions coexist. There is disagreement on whether abduction should include removals that only involve movement of an individual across state lines or refer more broadly to removals crossing local boundaries. There is also disagreement regarding whether definitions for abduction should incorporate or exclude competence requirements. Lastly, some conceptualizations of violations of rights consider abduction to be a specific member of a broader, more amorphous class of infringements.

Our decision to classify self-neglect as a distinct but related construct is consistent with the World Health Organization's typology of violence. This typology differentiates between violence a person inflicts upon himself or herself (Self-directed violence) and violence inflicted by another individual (Interpersonal violence). Self-neglect is considered a form of self-harm or self-abuse that may co-occur alongside or be triggered by elder abuse. Strategies for self-neglect prevention may differ from those for elder abuse due to important differences in associated risk factors and differences in applicable ethical and legal considerations that must be addressed (e.g., rights to self-determination when indicators of self-neglect are observed in a competent elder). Our decision is also consistent with conclusions drawn in other initiatives in the field of EA prevention which argue that self-neglect is an important phenomena, deserves its own research, and should be the central focus of a separate effort to achieve uniformity in its definition, measurement, and documentation (e.g., National Committee for The Prevention of Elder Abuse 2008 Symposium on Self-Neglect). Finally, the amount of attention given to phenomena such as resident-to-resident aggression has increased tremendously over the last decade. Resident-to-resident aggression is not a form of elder abuse. However, its occurrence produces injuries and wounds identical to those resulting from abuse and may result when institutions fail to take action to prevent or manage aggression or take actions that are not sufficient to assure resident health and safety. Both of these phenomena may produce outcomes as harmful as those of elder abuse. They may also intensify the impacts of abuse if they are experienced concurrently.

Abandonment

The desertion or willful disregard of an older adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

Abduction

Removal from the documented state of residence of any older adult who does not have the capacity to consent to such removal and/or preventing such persons from returning to their state of residence. Abduction may also include restraint of any conservatee (ward) without the consent of the conservator (guardian) or the court.

Criminal Record Identity Theft

Occurs when a caregiver or other person in a relationship where there is an expectation of trust gives an elder's name and personal information such as a drivers' license, date of birth, or Social Security number (SSN) to a law enforcement officer during an investigation or upon arrest, or presents to law enforcement a counterfeit license containing another person's

data. Involves posing as another person when apprehended for a crime.

Medical Abuse

Conceptual definitions for this term could not be found. Behaviors typically connected to the term include: inappropriate use of restraints; neglect leading to bedsores, unsanitary conditions, malnutrition, insufficient pain management, untreated medical conditions and poor personal hygiene; intentional recommendation or use of unnecessary medical procedures; causing illness in a person for the purpose of receiving attention or resources; forced feeding.

Resident-to-Resident Abuse/Aggression

Negative and aggressive physical, sexual or verbal interactions between residents of a long-term care facility that is unwelcomed by the recipient(s) and that have high potential to cause physical or psychological distress.

Self-Neglect

A nationally accepted, uniform definition of self-neglect has not been developed. Examples of existing definitions include:

- The behavior of an elderly person that threatens his/her own health and safety. This behavior generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, and safety precautions. This excludes situations in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice. (National Association of Adult Protective Service Administrators and the National Center on Elder Abuse)
- Meeting one or more of the following:
 - Persistent inattention to personal hygiene and/or environment
 - Repeated refusal of some/all indicated services which can reasonably be expected to improve quality of life
 - Self-endangerment through the manifestation of unsafe behaviors(e.g., persistent refusal to care for a wound, creating fire-hazards in the home) (Pavlou & Lachs)
- Lack of self-care and inattention to personal hygiene, domestic squalor, hoarding, apathy and disinterest for [one's] condition, social withdrawal, and stubborn refusal of help. (Clark et al.)
- The inability of a person to understand the consequences of his or her actions or inaction when the inability leads to or may lead to harm. There are two components to self-neglect:
 - The failure to provide for oneself the basic needs to avoid physical harm or suffering.
 - The inability to understand the consequences of that failure. (Oregon Department of Human Services)

Violation of Rights

The deprivation of any inalienable right, such as personal liberty/freedom of choice, assembly, speech, privacy, confidentiality, religious freedom, the right to vote. In long term care facilities, this term can be very broad, based on applicable state and/ or federal regulations, and can include the right to medical services, choice of physician, freedom to refuse psychotropic medications, right to remain in the facility, and freedom from physical restraint or involuntary seclusion.

TERMS ASSOCIATED WITH THE CIRCUMSTANCES AND CONSEQUENCES OF ELDER ABUSE

Incident

A single act or series of acts that are connected to one another and that may persist over a period of minutes, hours, or days. One perpetrator or multiple perpetrators may commit an incident.

Activities of Daily Living (ADLs)

Everyday tasks related to personal care usually performed for oneself in the course of a normal day, including bathing, dressing, grooming, eating, walking, taking medications, eliminating, and other personal care activities.

Instrumental Activities of Daily Living (IADLs)

Activities related to independent living, such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

Capacity

The ability, as defined by statute, courts, or clinicians, to perform specific tasks

Economic or Financial Dependency / Dependence

The degree to which one person relies on another person for direct or indirect monetary assistance or support to meet basic needs for food, water, shelter, clothing, or health care.

Report/Reported

A formal or official account or statement regarding an alleged incident of Elder Abuse, made to the appropriate authorities and agencies.

Investigation / Investigated

An evaluation of the potential victim after a report has been filed to appropriate authorities. Also more broadly involves collection of information regarding the circumstances of a reported incident. Can be initiated or carried out by numerous agencies including, but not limited to Adult Protective Services, Law Enforcement, or Long Term Care Ombudsmen.

Substantiated/Validated Report

A report that has been investigated and subsequently supported by proof, evidence, or corroborating information.

Disability

A physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment (Americans With Disabilities Act Of 1990, As Amended).

Disease

A pathological condition of a body part, an organ, or a system resulting from various causes, such as infection, genetic defect, or environmental stress, and characterized by an identifiable group of signs or symptoms.

Although the biological significance of race has been questioned, data on race are used in public health surveillance and in epidemiologic, clinical, and health services research.

The categories below represent a social-political construct designed for collecting data on the race and ethnicity of broad population groups in the United States. For more than 20 years, the Federal government has promoted the use of a common language to ensure uniformity and comparability of data on race and ethnicity. Development of the data standards stemmed in large measure from new responsibilities to enforce civil rights laws. Data were needed to monitor equal access in housing, education, employment, and other areas for populations that historically had experienced discrimination and differential treatment because of their race or ethnicity. The standards are used not only in the decennial census (which provides data for the “denominator” for many measures), but also in household surveys, on administrative forms (e.g., school registration and mortgage-lending applications), and in medical and other research. Race is a concept used to differentiate population groups largely by physical characteristics transmitted by descent. This concept lacks clear scientific definition, as racial categories are neither precise nor mutually exclusive. The common use of race in the United States draws upon differences not only in physical attributes, but also in ancestry and geographic origins. HHS on Oct. 31, 2011, published final standards for data collection on race, ethnicity, sex, primary language and disability status, as required by Section 4302 of the Affordable Care Act. The law requires that data collection standards for these measures be used, to the extent practicable, in all national population health surveys. They will apply to self-reported information only. The law also requires any data standards published by HHS comply with standards created by the Office of Management and Budget (OMB).

Incident ID may be assigned by the agency compiling Elder Abuse (EA) surveillance data, or it

END NOTES

The term public health surveillance refers to: the ongoing and systematic collection, analysis, and interpretation of health-related data for use in setting priorities and making other decisions regarding prevention efforts. Several global terms are used by others to label the behaviors and phenomena described in this document. Some examples of other terms include elder abuse, elder neglect, elder mistreatment, elder maltreatment, senior abuse, abuse in later life, abuse of older adults, and inadequate care of the elderly. Early CDC work utilized the term “elder maltreatment.” Although “elder maltreatment” is occasionally used in the field, it is used much less than terms such as “elder abuse” or “elder mistreatment.” The term elder maltreatment also lacks widespread use or recognition by lay audiences and often requires further clarification to facilitate comprehension. Lastly, the term maltreatment is not embraced by many experts, front line professionals or older survivors because it is perceived as a softer term which minimizes or does not adequately communicate the traumatic events and devastation experienced by many older victims. Accepted alternatives to the term “elder maltreatment” are “elder mistreatment,” “elder abuse, neglect, and exploitation,” and “elder abuse.” While the term “elder mistreatment” is more widely accepted, its use, unfortunately, presents the same problems as the use of the term elder maltreatment. The term “elder abuse, neglect, and exploitation” is closer to the language used by most stakeholders. However, it is argued that treating neglect, and by extension exploitation, as wholly separate and distinct constructs reinforces the tendency to focus in isolated ways on either a perpetrator’s action or inaction. He believed the true concern should be the end results of these behaviors which may be similar or not easily

distinguishable in some cases. Moreover, physical abuse, neglect, and exploitation may co-occur or have underlying behavioral or situational drivers that may overlap greatly. Therefore, CDC, in consultation with members of the expert panel, decided to use the term “elder abuse.” The term has the broadest public and professional recognition, has the capacity to accommodate the broadest variety of conceptually relevant behavioral categories, and can be appropriately used as an omnibus label for various situations where older adults or elders have been harmed as a result of being handled, treated, or used wrongly or improperly by caregivers or other persons in relationships where there is an expectation of trust.

Elder Abuse, as specified in the "Uniform Definitions" and used throughout the "Recommended Core Data Elements," refers to intentional acts or failures to act by a caregiver or another person in a relationship involving an expectation of trust, that causes or creates a serious risk of harm to an older adult.

ELDER ABUSE SURVEILLANCE: UNIFORM DEFINITIONS

Elder abuse – including physical, sexual, and psychological abuse, as well as neglect, abandonment, and financial exploitation – affects about five million Americans each year, causing untold illness, injury and suffering for victims and those who care about and for them. Although we do not have a great deal of data quantifying the costs of elder abuse to victims, their families, and society at large, early estimates suggest that such abuse costs many billions of dollars each year – a startling statistic, particularly since just one in 24 cases is reported to authorities. Given the aging population and the widespread human, social, and economic impact of elder abuse, a broad range of stakeholders and experts were consulted on how to enhance both public and private responses to elder abuse.

Among the many priorities identified in this Roadmap, five stand out: The Top Five Priorities critical to understanding and reducing elder abuse and to promoting health, independence, and justice for older adults, are:

1. Awareness: Increase public awareness of elder abuse, a multi-faceted problem that requires a holistic, well-coordinated response in services, education, policy, and research.
2. Brain health: Conduct research and enhance focus on cognitive (in)capacity and mental health – critical factors both for victims and perpetrators.
3. Caregiving: Provide better support and training for the tens of millions of paid and unpaid caregivers who play a critical role in preventing elder abuse.
4. Economics: Quantify the costs of elder abuse, which is often entwined with financial incentives and comes with huge fiscal costs to victims, families and society.
5. Resources: Strategically invest more resources in services, education, research, and expanding knowledge to reduce elder abuse.

Developing a Roadmap to set strategic priorities to advance elder justice involved collecting information from numerous sources. The data were collected, with guidance from subject matter experts from around the country, in several phases including: Using a concept mapping process to solicit the perspectives of 750 stakeholders who were asked to identify the most critical priorities for the field;

- Convening facilitated discussions with experts on six particularly important topics: (1) diminished capacity/mental health, (2) caregiving, (3) diversity, (4) prevention, (5) screening, and (6) victim services;
 - Conducting leadership interviews with high-level public officials, thought leaders, and heads of influential entities regarding how best to gain traction, engage vital partners, and set and implement an agenda to promote elder justice; and
 - Compiling a bibliography and list of resources including articles, books, DVDs, curricula and toolkits relevant to the issues and priorities identified in the project.
- This process resulted in the identification of the Top Five Priorities noted above, and specific recommendations identified by Roadmap contributors, who sorted them into three categories:
- First Wave Action Items – Priorities to address first, chosen by subject matter experts based on criteria outlined on page 9.
 - High Priorities by Domain – A wider range of priorities sorted by the Roadmap’s four domains: Direct Services, Education, Policy, and Research, for users interested in a more in-depth list of options, and the reasons those priorities were deemed important.
 - Universal Themes that Cut across Domains – Vital issues that arose repeatedly.

A Dynamic Document

This Roadmap is intended primarily to be a strategic planning resource by the field, for the field to advance our collective efforts to prevent and combat elder abuse. It is a dynamic document that can be adapted and used by grassroots and community groups, multidisciplinary teams, and local, state, and national governmental and non-governmental entities, all of which have critical and complementary roles to play in tackling and implementing the recommendations identified in this document.

While the views and information contained in this document do not reflect or represent the official positions or policies of the federal government, they have already helped to inform certain federal efforts. For example, the Roadmap helped to inform the structure of and subjects addressed at the inaugural meeting of the Elder Justice Coordinating Council and to help target certain federal data collection, research, and training initiatives and projects. There is much to do to address elder abuse. This Roadmap is just the beginning.

This initiative asked 750 stakeholders to complete, with as many ideas as they wished, the following statement: “To understand, prevent, identify or respond to elder abuse, neglect, or exploitation, we need...” Their responses provided the foundation for a dialogue involving various subject matter experts from across diverse disciplines, fields, professions, and settings, and resulted in this report, which was drafted by:

- Marie-Therese Connolly, JD, MacArthur Foundation Fellow; Senior Scholar, Woodrow Wilson International Center for Scholars
- Bonnie Brandl, MSW, Director, National Clearinghouse on Abuse in Later Life (NCALL), End Domestic Abuse Wisconsin
- Risa Breckman, LCSW, Weill Cornell Medical College, Division of Geriatrics and Palliative Medicine; Director, New York City Elder Abuse Center

The recommendations, points of view, and opinions in this document are solely those of the authors, subject matter experts and stakeholders and do not represent official positions or policies of either the U.S. Department of Justice or the U.S. Department of Health and Human Services.

I. THE ELDER JUSTICE ROADMAP

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- B. The Human and Economic Toll
- C. Challenges in Responding
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II. PRIORITIES, ACTION ITEMS, AND UNIVERSAL THEMES

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- D. List of Stakeholders' Statements
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7. Financial Abuse

EXAMPLES OF FINANCIAL ABUSE OF PEOPLE WITH DEMENTIA

(as reported by service providers)

- A mother with dementia was moved from her home by her daughter, and without the knowledge of her son who lived in the UK. She was taken to live with the daughters' family and was locked in a bedroom. The mother executed a Power of Attorney at a time when she lacked capacity. Her house was sold without her knowledge and the funds were used to pay off the mortgage on the daughters' house and buy a four wheel drive. It was also used to buy

a family holiday, pay for school fees and a trip to New York for one grandchild. The mother therefore lacked funds for a bond for a residential facility, which she would otherwise have been able to access. Instead she was locked away with no stimulation or independence until her son returned to Australia and discovered the abuse.”

- An elderly widow (without immediate family) with dementia was befriended by a real estate agent. He was a friend of her gardener. She owned her own home. He charmed her and she took mortgages out over her home to lend him money and buy him a car. She is now in a nursing home. Two thirds of her assets have been taken. It was an aged care assessment team member who suspected the abuse but only after most of the funds had been taken.”
- “A nephew would present his aunt with a blank cheque and tell her he was going to purchase groceries. He would fill in the amount himself after she signed then make the cheque out for thousands of dollars. He was working towards having her discharged to his care and purchased a new four bedroom home where he purported he would look after his aunt. He also purchased a Mercedes Benz!”
- “An unemployed man moved in with his mother ‘to care for her’ but in fact he spent all her money on drugs and alcohol and she could not recognize it was happening. Neighbors suspected it was happening but were helpless to support this lady who refused to acknowledge her dementia or her sons’ abuse.”
- “The daughter and her partner (who has Power of Attorney) moved in with mum who has dementia. They have four children and decided the house was too small so sold and purchased a new two story home. Their mother is in small room downstairs with a bathroom in the family laundry but the home and all attached amenities are in her name. Often her accounts for care and services cannot be paid...but she is unwilling to go against her daughter as she says ‘she will be put in a nursing home if she stop her daughter from using money’.”
- “A son and daughter, who were both solicitors, changed the title deeds on properties owned by their parents into their own names. They had systematically sold the parents’ share portfolio and recouped the funds to themselves. Their parents are living in an inaccessible and very small rental property – effectively leaving them with no assets. Neither of the parents are aware as they both have cognitive decline and as they trusted their children they signed anything put in front of them.”

Executive Summary

Financial abuse is defined by the World Health Organization (WHO) as “the illegal or improper exploitation or use of funds or resources of the older person”. However this definition can be interpreted in different ways due to subjective understandings of what constitutes abuse. There are many risk factors for financial abuse, not just dementia. It is therefore important to consider family relationships and dynamics, social and cultural connections, physical and mental health and wellbeing and financial standing. Other forms of abuse, such as physical abuse and neglect or psychological and emotional abuse, may be occurring at the same time as financial abuse. NSW conducted research to examine how financial abuse of people with dementia occurs and what can be done to prevent or reduce the incidence of it. We held focus groups with our eight consumer advisory groups, surveyed service providers and professionals from a range of sectors, and interviewed family members of victims of financial abuse. Examples of financial abuse of people with dementia are included. Their stories highlight the ways in which financial abuse is perpetrated and the devastating effects it has for victims and their loved ones. It is extremely difficult to calculate the prevalence of financial abuse of people with dementia as it occurs in a multitude of ways and much of it remains unreported to authorities. The percentage of cases that go unreported is likely to be high due to feelings of stigma, shame and

embarrassment experienced by people who are victims of financial abuse and their families. People with dementia may have diminished capacity to recall the financial abuse or lack insight to understand the abuse.

Much financial abuse is perpetrated within families. Some of this abuse would likely be considered 'inheritance impatience'. More than sixty-five percent of respondents to our survey indicated that children are most often identified as the perpetrators of abuse, and over ninety percent of respondents indicated someone known to the victim is most often the perpetrator. Our research suggests that a considerable proportion of financial abuse of people with dementia is perpetrated by people appointed as an attorney under a Power of Attorney not acting in the interests of the person with dementia. Another enabler of financial abuse is the failure of some lawyers to assess the capacity of an individual to appoint a new POA. Not all financial abuse of people with dementia is perpetrated by family members and those holding an EPOA though. People with dementia, particularly those who live alone, are susceptible to exploitation and abuse by neighbors and friends who prey on their vulnerability.

We found that people with dementia, family members and service providers are reluctant to report financial abuse. Victims are often in a relationship of dependence with the perpetrator and may fear repercussions if they report the abuse. There is also confusion at all levels in the community about who to report abuse to. When financial abuse is reported there are challenges in investigating cases. Financial abuse can be difficult to substantiate and prove, especially when the victim has dementia.

A number of possible strategies to reduce the incidence of financial abuse of people with dementia and to resolve cases satisfactorily emerged from the research. These include reporting of financial abuse of people with dementia, and registration and monitoring of POAs

What is Financial Abuse?

The World Health Organization (WHO) defines elder financial abuse as "the illegal or improper exploitation or use of funds or resources of the older person. Financial abuse can be interpreted differently and difficult to detect due to subjective understandings of what constitutes abuse. For example, some cultural groups and families have particular attitudes and different norms with regard to the sharing of money and property. Family-mingled funds and resources lead to different understandings of what constitutes improper use. The Human Rights Commission defines financial abuse as "when a person you trust uses that relationship of trust to gain access to your money or property" and identifies the varied forms financial abuse can take, including:

- Pressure to act as guarantor for a loan;
- Pressure to transfer or sell property;
- Pressure to give away money;
- Loans not being repaid; or
- Persons authorized to manage your money not acting in your best interest, or using your money for themselves.

Financial abuse tends to exist in the grey area between thoughtless practice and outright theft", noting that it is "usually not a single event but a process that develops over time and so it is difficult to assess at what point a well-intentioned but ill-considered financial act tips over into abuse, or when borrowing money becomes misappropriation.

Planned financial abuse is deliberately targeted and may include the ‘grooming’ of a vulnerable person to develop a relationship of trust. Loneliness and social isolation may play a part in marking a vulnerable person as a potential target for predatory abusers. Opportunistic abuse is more likely to emerge over time and be perpetrated by someone with a Power of Attorney who may initially act legitimately but take liberties because they can or because they find themselves in difficult circumstances such as debt. Interpretational differences lead to varied reporting of prevalence statistics of elder financial abuse. The WHO definition is broad; it encompasses financial abuse perpetrated by people known to the victim as well as abuse perpetrated by strangers and institutions, by way of scams and fraud. For the purposes of this project we defined financial abuse as abuse perpetrated by people in a position of trust. Scammers may approach people in many different ways, including through phone calls, emails, letters and door-knocking. People who fall victim to scams should report the scam.

Why are people with Dementia Vulnerable to Financial Abuse?

The term dementia describes the symptoms of a large group of illnesses which cause a progressive decline in a person’s functioning. It encompasses the progressive loss of memory, intellect, rationality, social skills and physical functioning. A person may have symptoms for several years before dementia is diagnosed. A diagnosis of dementia does not necessarily mean that a person can no longer make decisions for themselves. Legislation throughout the United Nations (UN) Conventions on the Rights of People with a Disability (CORPD) and the Common Law presumption of capacity where it is assumed a person has capacity unless it can be proven that they do not. It is usually the responsibility of the treating health professional to determine whether or not someone has capacity to manage their financial affairs and other matters.

As symptoms progress, a person with dementia will lose the ability to make financial decisions and manage their finances. The gradual loss of capacity and decline in cognitive abilities increases the vulnerability of people with dementia and their risk of falling victim to financial abuse and exploitation. Financial abuse does not include financial mismanagement of their own funds by a person with dementia. The lack of cognitive capacity to manage their finances makes people much more vulnerable and increases their risk of being financially abused, exploited and defrauded. Rapid advances in technology and the changing nature of banking, including the rise of online transactions and the declining use of cheques, can increase the vulnerability of people with dementia as these changes are difficult to understand and navigate yet they can also offer some protections as it can be easier to detect abuse.

Signs of Financial Abuse

There are many risk factors for financial abuse, not just dementia. It is therefore important to consider family relationships and dynamics, social and cultural connections, physical and mental health and well being and financial standing. Other forms of abuse may also be occurring at the same time as financial abuse, including neglect and physical abuse, psychological or emotional abuse. Social isolation is also a risk factor for financial abuse. Research indicates that adult children, grandchildren and other relatives are the most likely perpetrators of financial abuse.

Signs of financial abuse include:

- Fear, stress and anxiety expressed by a person with dementia

- Unfamiliar or new signatures on checks and documents of a person with dementia
- The inability of a person with dementia to access bank accounts or statements
- Bank, credit and debit cards and accompanying Personal Identification Numbers (PINs) of a person with dementia handed over to another person
- Significant withdrawals from accounts of a person with dementia
- The accounts of a person with dementia suddenly moved to another financial institution
- Significant changes to a will of a person with dementia
- Isolation and control of a person with dementia by caregiver
- Evidence of undue influence e.g. coercive behavior by another person
- Lack of concern for the welfare of a person with dementia (signs of neglect)

Not all financial abuse of people with dementia is perpetrated by family members and those holding an POA. People with dementia, particularly those who live alone, are susceptible to exploitation and abuse by neighbors and existing or new found friends who prey on the vulnerability of the person due to their declining cognitive capacity. Several members of consumer groups told of cases of new ‘friends’ who come on to the scene when dementia became apparent. For example, one consumer knew of a woman at a local church who befriended a person with dementia and was subsequently investigated for theft. Another consumer spoke of women trying to take advantage of their father following his diagnosis of dementia. The women made a point of befriending him and then asked him for gifts and money. The family changed their fathers’ telephone number so the woman could not call him.

“Tom”

Tom, at almost 80 years of age, has lived in the same country town his whole life. He has lived on his own since his wife died several years ago and has been quite lonely as none of his five children live close by. In recent years Tom’s family were concerned about some memory loss and confusion but thought it was just old age. Two years ago a woman in her early forties moved to the town and befriended Tom. Tom’s daughter Linda describes this woman, Melanie, as charming, cunning and manipulative. Tom’s family were concerned about his new friend as he was not calling them as much and when he did he constantly talked about Melanie. Linda would often make the seven hour trip to visit her father and during one of her visits, Melanie came over for dinner. Linda reported: “I felt sick the whole time she was there; she was touching dad’s hand and calling him ‘dear’. And she knew the house so well. I couldn’t believe she knew where everything was.” A few months later, Tom told Linda that Melanie wanted to buy a house and was asking him to go to auctions with her. Not long after that Tom seemed depressed when his children spoke to him and he stopped talking about Melanie. When Linda asked about Melanie, Tom told her that Melanie would get angry at him for visiting and yell at him. The family then found out that Tom had bought a house for Melanie to rent from him. Tom had also paid for paint, carpet, curtains, air conditioning, and a kitchen refurbishment. Linda estimates that he may have spent up to \$20,000 fixing the house up for Melanie. Six months after Tom purchased this house, he was diagnosed with dementia. Around this time Linda found out that Tom’s regular solicitor was not used in the purchase of the house. She contacted the new solicitor who was so relieved that Linda called because Melanie was demanding that the title deeds of the property be transferred to her. Fortunately the solicitor refused to do this. Linda also found out that Melanie convinced Tom to sign a handwritten agreement reducing her rent to \$50 a week. Tom did not realize what Melanie had done; he told Linda: “she just told me that I had to sign it so I just signed it.” Following these events, Linda activated the EPOA that she had for her father and asked Melanie to vacate the house. Eventually Melanie did move out and they now have new tenants living there and are trying to sell the property.

Linda has no idea how much money Melanie may have acquired from Tom, who would take large amounts of money out of his account and store it in a home safe. Linda has since found out that Tom's friends and neighbors, as well as the solicitor and real estate agent, were all concerned about Tom's relationship with Melanie but did not want to interfere. They are now all aware of Tom's dementia diagnosis and watch out for him in between frequent visits from his children. Of this experience Linda says: "I never thought about reporting it to police because she's really scary...she frightens me and she's threatened other people in town...but she's clever and charming as well...and I don't know how much money she got and I don't want to put us through that."

"Henry"

Henry was financially abused by his partner, Edith, and Edith's children. Henry and Edith lived together for ten years. Edith, two years older than Henry, initially moved in as his housekeeper but over the years their relationship developed. Through an EPOA Henry had appointed his only son, John, as his attorney. Henry's family describe him as a dominant personality who was stubborn and strong willed. However Edith was able to manipulate and control Henry and isolated him from his relatives. Henry and Edith were married by a clerk of the court. John reported: "Dad wasn't good on the day he got married. He was blank, he was non-communicative. We actually thought he was drugged. Now we realize it was part of the dementia." It took his family quite a while to realize that Henry's behaviors and personality changes were symptoms of dementia. Henry was diagnosed with dementia in 2011 in his mid-eighties. Following his diagnosis, Edith moved out and refused to play any part in caring for Henry. When she left she told Henry's family that she was "going to take him for every penny". John assumed responsibility for organizing care services for Henry, and as his dementia progressed, eventually moved him to a dementia-specific nursing home. After investigating Henry's finances, John and his wife uncovered the extent of the financial abuse perpetrated by Edith and her family. They estimate that Edith and her children stole in excess of one million dollars from Henry's estate. They also discovered that on the day of Henry and Edith's marriage, Henry had signed a new Will which would benefit Edith and her family immensely. The abuse began with Edith's sons borrowing \$50,000 from Henry which he never paid back. When confronted about this unpaid debt, they changed their story, telling John: "He's got dementia. It was all a gift. Prove it wasn't." Henry had owned several properties. Over time these were sold, with the funds deposited into Henry's bank accounts. Following their marriage, Edith gained joint one-sign access to Henry's accounts. When John became aware of what had occurred he spoke to Henry's bank and his account was frozen. However they were not able to provide details of the transactions because, although John was Henry's attorney, Edith was still an account holder. Edith withdrew \$2000 out of the account when she realized that the family had figured out something was happening. She then went to the branch to try to withdraw all of the money but the account was frozen by that time. When Henry died, the bank allowed Edith to remove over \$500,000 from the joint account as the account was unfrozen following Henry's death. Edith did not have Henry's death certificate and the bank stated that they released the funds based on survivorship. Bank staff told John they wanted to tell him that the account was unfrozen but that legally they couldn't because John was not Henry's attorney after death. John and his wife have spent close to \$200,000 in legal fees to get justice for Henry and the ordeal took a considerable toll on their health. Henry's three grandchildren, who were supposed to receive twenty percent of his estate each, have inherited almost nothing.

People with dementia and their families

As expected, survey respondents reported that their clients with dementia do not understand their rights when they are victims of financial abuse. Ninety five percent of respondents agreed that victims of financial abuse do not pursue resolution because they do not know how to take action and they do not have the capacity to do so. An important consideration is that people with dementia who have been financially abused may not have the cognitive capacity or insight to know that they have been a victim of financial abuse. The onus to report is therefore on family members, advocates or service providers who become aware of what has happened. Some members of consumer advisory groups indicated that they would not know who to report abuse to if it did occur to themselves or the person they care for. The family members of victims of financial abuse interviewed for this project struggled to report the instances of financial abuse. They either did not report the abuse or faced barriers in cases being investigated and resolved. “There are other factors that need to be considered also such as fear of social isolation. Clients with or without dementia are often aware of the financial exploitation but would prefer this went on and the abuser remained. People with dementia and their families As expected, survey respondents reported that their clients with dementia do not understand their rights when they are victims of financial abuse. Ninety five percent of respondents agreed that victims of financial abuse do not pursue resolution because they do not know how to take action and they do not have the capacity to do so.” Instances of financial abuse of people with dementia also go unreported because victims are often dependent upon the perpetrators of abuse. People with dementia may not be willing to report the abuse because they do not want a member of their family in trouble with the law and fear that there will be repercussions if they speak out. Seventy-one percent of survey respondents believe that fear of retribution prevents people reporting financial abuse, and ninety-five percent of respondents agreed that victims of abuse do not pursue resolution because they do not want a member of their family charged.

8. The Elder Justice Roadmap

Responding to an Emerging Health, Justice, Financial, & Social Crisis

Elder abuse including physical, sexual, and psychological abuse, as well as neglect, abandonment, and financial exploitation— affects about five million Americans each year, causing untold illness, injury and suffering for victims and those who care about and for them.

Although we do not have a great deal of data quantifying the costs of elder abuse to victims, their families, and society at large, early estimates suggest that such abuse costs many billions of dollars each year— a startling statistic, particularly since just one in 24 cases is reported to authorities. Given the aging population and the widespread human, social, and economic impact of elder abuse, a broad range of stakeholders and experts were consulted on how to enhance both public and private responses to elder abuse. Among the many priorities identified in this Roadmap, five stand out: The Top Five Priorities critical to understanding and reducing elder abuse and to promoting health, independence, and justice for older adults, are:

- 1. Awareness:** Increase public awareness of elder abuse, a multi-faceted problem that requires a holistic, well-coordinated response in services, education, policy, and research.
- 2. Brain health:** Conduct research and enhance focus on cognitive (in)capacity and mental health – critical factors both for victims and perpetrators.
- 3. Caregiving:** Provide better support and training for the tens of millions of paid and unpaid caregivers who play a critical role in preventing elder abuse.

4. Economics: Quantify the costs of elder abuse, which is often entwined with financial incentives and comes with huge fiscal costs to victims, families and society.

5. Resources: Strategically invest more resources in services, education, research, and expanding knowledge to reduce elder abuse.

The Elder Justice Roadmap Process

Developing a Roadmap to set strategic priorities to advance elder justice involved collecting information from numerous sources. The data were collected, with guidance from subject matter experts from around the country, in several phases including:

- Using a concept mapping process to solicit the perspectives of 750 stakeholders who were asked to identify the most critical priorities for the field;
- Convening facilitated discussions with experts on six particularly important topics: (1) diminished capacity/mental health, (2) caregiving, (3) diversity, (4) prevention, (5) screening, and (6) victim services;
- Conducting leadership interviews with high-level public officials, thought leaders, and heads of influential entities regarding how best to gain traction, engage vital partners, and set and implement an agenda to promote elder justice; and
- Compiling a bibliography and list of resources including articles, books, DVDs, curricula and toolkits relevant to the issues and priorities identified in the project. This process resulted in the identification of the Top Five Priorities noted above, and specific recommendations identified by Roadmap contributors, who sorted them into three categories:
 - First Wave Action Items – Priorities to address first, chosen by subject matter experts based on criteria outlined in this document
 - High Priorities by Domain – A wider range of priorities sorted by the Roadmap’s four domains: Direct Services, Education, Policy, and Research, for users interested in a more in-depth list of options, and the reasons those priorities were deemed important.
 - Universal Themes that Cut across Domains – Vital issues that arose repeatedly.

This Roadmap is intended primarily to be a strategic planning resource by the field, for the field to advance our collective efforts to prevent and combat elder abuse. It is a dynamic document that can be adapted and used by grassroots and community groups, multidisciplinary teams, and local, state, and national governmental and non-governmental entities, all of which have critical and complementary roles to play in tackling and implementing the recommendations identified in this document.

While the views and information contained in this document do not reflect or represent the official positions or policies of the federal government, they have already helped to inform certain federal efforts. For example, the Roadmap helped to inform the structure of and subjects addressed at the inaugural meeting of the Elder Justice Coordinating Council¹ in October 2012, and to help target certain federal data collection, research, and training initiatives and projects. There is much to do to address elder abuse. This Roadmap is just the beginning.

A. The Problem

Elder abuse “includes physical, sexual or psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity, that occurs in any setting (e.g., home, community, or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability.” (See note on definition, Appendix A.) In other words, any older adult, in any family, may experience elder abuse. Sometimes individuals bear responsibility for the abuse. Sometimes broken or

ineffective systems and entities bear responsibility. Much more research is needed, but existing data indicate that:

- One out of every ten people ages 60 and older who live at home suffers abuse, neglect, or exploitation.
 - In several small studies, about half of people with dementia suffered from abuse or neglect by their caregivers.
 - Cognitive impairment reduces financial capacity, increasing risk of financial exploitation.
 - High rates of neglect, poor care or preventable adverse events persist in nursing homes and other long-term care settings where more than two million people (most of them elderly) live.
 - About two-thirds of elder abuse victims are women.
 - African American,⁷ Latino,⁸ poor, and isolated older adults are disproportionately victimized.
 - For every 1 case of elder abuse that comes to light, another 23 remain hidden.¹⁰
- “Facts matter. So do stories. We need to do a better job of getting out the word that these issues affect everyone.”

B. The Human and Economic Toll

Elder abuse triggers downward spirals for many victims, eroding their health, financial stability, and well-being. It also causes untold suffering for millions of people of all ages. That suffering, in turn, needlessly depletes scarce resources of individuals, families, businesses, charities, and public programs (like Medicare and Medicaid). Research is beginning to illuminate the huge cost of elder abuse:

- Elder abuse triples the risk of premature death and causes unnecessary illness, injury, and suffering.
- Victims of elder abuse are four times more likely to be admitted to a nursing home¹² and three times more likely to be admitted to a hospital.
- Understaffing at nursing homes leads to a 22% increase in unnecessary hospitalizations.
- Most adverse events in nursing homes – due largely to inadequate treatment, care and understaffing – lead to preventable harm and \$2.8 billion per year in Medicare hospital costs alone (excluding additional – and substantial – Medicaid costs caused by the same events.)
- Financial exploitation causes large economic losses for businesses, families, elders, and government programs, and increases reliance on federal health care programs such as Medicaid. Research indicates that those with cognitive incapacities suffer 100% greater economic losses than those without such incapacities.
- One study of older women found that verbal abuse only leads to greater declines in mental health than physical abuse only.
- Elder abuse causes victims to be more dependent on caregivers. As a result of providing care, caregivers experience declines in their own physical and mental health and their financial security suffers.
- The cumulative toll of elder abuse has not yet been quantified but is estimated to afflict more than 5 million people and cost many billions of dollars a year. Emerging evidence indicates that prevention could save lives and prevent illness, injury and suffering, while also yielding major cost savings. “It’s important to include cost-benefit analyses. People ask: ‘If we do this, can we save costs?’ So those cost-benefit data are valuable.” – leadership interview Archstone Foundation

C. Challenges in Responding

In communities across the country, diverse multidisciplinary groups of people trying to address elder abuse in their professional and personal lives are working together to find ways to prevent and respond to the problem. States are grappling with enacting appropriate laws and creating programs, roles for responders, and sanctions for abusers. These efforts are largely uncoordinated, lack sufficient resources, and are uninformed by existing data and program models.

Elder abuse is not an easy problem to address: It can manifest itself in many ways – an older parent isolated and neglected by an adult child or caregiver; domestic violence by a partner (long-term or new), adult child or caregiver; sexual assault by a stranger, caregiver or family member; abuse or neglect by a partner with advancing dementia; financial exploitation by a stranger, trusted family member or professional; or systemic neglect by a long-term care provider that hires too few staff members, provides insufficient training to its staff, and expends too few resources on resident care. As a result, elder abuse requires responses that take an array of factors into consideration: Norms can vary by racial, ethnic, and religious identity (such as relating to caregiving and money) that can shape the context of elder abuse. Shame, fear, love, loyalty, pride, and a desire to remain independent often influence the decisions of older people at risk. Cognitive incapacity and isolation are accompanied by high rates of elder abuse, and also can influence the decision-making of older adults and their ability to access and participate in services. And Adult Protective Services (“APS”) workers report that mental health and substance abuse issues often are present among perpetrators, victims, or both. Thus, effective prevention, investigation and intervention require cultural competency and sensitivity to a broad array of issues. In addition, one of the greatest challenges in addressing elder abuse is navigating the right balance among autonomy, safety, and privacy goals. In short, elder abuse does not fit a single profile. It is a complex cluster of distinct but related phenomena involving health, legal, social service, financial, public safety, aging, disability, protective services, and victim services, aging services, policy, research, education, and human rights issues. It therefore requires a coordinated multidisciplinary, multi-agency, and multi-system response. Yet, as noted by the General Accountability Office in 2011,²⁰ services, education, policy, and research are fragmented and under-resourced. These challenges have been magnified by the lack of a coordinated strategic agenda. This Roadmap is intended to address that gap. “There’s great concern about elder abuse. But without resources it’s really hard to be anything but frustrated about it.” – leadership Interview Madeline Kasper

D. Elder Abuse is a Problem with Solutions

This Roadmap seeks to forge a path to solutions with an informed, coordinated, public, and private effort at the local, state, and national levels. This Roadmap offers opportunities for engagement by numerous constituencies – the public, state and local officials, professionals who routinely address elder abuse, allied professionals in related fields, policy makers, educators, researchers, caregivers, others who work to reduce elder abuse, and older adults themselves. It is time not only to identify the problems, but also to expand our knowledge about successful strategies and implement common sense, cost-effective solutions to stem this rising epidemic of elder abuse.

Communities have different needs and resources when it comes to addressing elder abuse. The priorities identified in this Roadmap provide ample opportunity for organizations, practitioners, and other interested individuals and entities to participate in tackling aspects of the problem that

are most relevant to them. No single entity can address elder abuse by itself. Everyone can make a difference.

The vast suffering, cost and dislocation caused by elder abuse demand a commensurate investment of resources. Such an investment could yield substantial gains.

“The definition of successful advocacy on these kinds of issues is ‘gentle pressure applied relentlessly.’ You just never stop. And eventually, you move things forward.” – leadership interview Sally Aristei Photography

Direct Services Action Items

- Designate more prosecutors and prosecution units dedicated to pursuing elder abuse.
- Include older people’s input in all aspects of elder justice efforts.
- Develop more multidisciplinary teams throughout the country that have adequate support for facilitators and operations.
- Ensure protection from and response to abuse, neglect and exploitation of individuals receiving long-term supports and services, regardless of setting.
- Ensure that existing domestic violence, sexual assault, and other victim assistance programs better meet the needs of older victims by allocating resources, collecting data, developing, and evaluating programs, and incorporating elder abuse issues into training and technical assistance.
- Develop prevention, intervention, and surveillance methods tailored to protect cognitively impaired older people in all settings.
- Each idea generated in the concept mapping process was assigned a number (see Appendix D). These numbers appear in parentheses beside the action item to which that idea corresponds. Some action items merge two or more ideas into a single statement. “You need to overcome people’s reluctance to talk about this stuff. They don’t want to believe it has anything to do with them. They think, ‘I don’t know anyone who would do that...’” (leadership Interview Education Action Items Connolly Family Education Action Items)
- Educate all types of caregivers about elder abuse.
- Create and implement a national elder abuse education and training strategic plan. “Training is not just talking at people. There are techniques and technology out there for adult education. You need to invest in being good adult educators. That’s part of capacity building. But most people don’t know how to do this.” – leadership interview “We desperately need to develop ways to train individuals on the front lines about cognitive impairment and decision-making capacity and how to assess these. Practitioners are poorly informed and they need to catch up to where science has taken us in the last 10-20 years. The average caseworker will tell you – they use outdated questionnaires and screening tools. That needs to stop.” – facilitated discussion

Policy Action Items

- Improve law, policies, training, oversight, and data collection related to substituted decision-making, including abuse of powers of attorney, guardianship, and conservatorship.
- Build a strong movement to advance elder justice, informed by key teachings from other social movements.
- Develop national APS definitions and standards, including topics such as feasible caseloads, collaborations, training requirements, and data collection. “To get something done, you don’t have to convince everyone. Just the right people.” – leadership interview “We can say that elder abuse is really important but it doesn’t mean the resources come. And funding decisions often

are far more influenced by external players than by internal agency players.” – leadership interview Archstone Foundation Research Action 4Items Roger Tully “Could you create a prediction model? When a person reaches age X, they get some assessment and education about the likelihood they’ll fall victim to abuse, neglect, or exploitation because of the following factors: age, cognitive status, financial security or lack thereof, and family and social support. If 3 of 4 factors are present, their probability of being mistreated by age, say 80, is XYZ. So, what factors are ‘treatable?’ What can we do to prevent them proactively from going down that road?” – leadership interview Research Action Items

- Conduct research, including program evaluation, to determine the effectiveness of interventions that are used to address elder abuse.
- Measure the economic cost of elder abuse and neglect (e.g., facility placements, hospitalizations, trips to the emergency room, lost assets and wages, etc.) in order to identify areas of cost savings gained by addressing the problem. “If you could link the cost of elder abuse to Medicare and Medicaid, that could be very powerful.” – leadership interview

Direct Services Priorities

The Direct Services region of the Roadmap focuses on front-line practitioners and the services and responses they provide, including: (1) caregivers; (2) first responders and investigators such as adult protective services workers, emergency medical technicians (“EMTs”), law enforcement and state licensing and oversight agencies; (3) professionals who might identify abuse and make referrals to an investigative or services agency such as health and mental health providers, case managers and discharge or care coordinators; (4) aging services network personnel, senior centers, meals on wheels, social service providers, guardians, powers of attorney and others; (5) victim advocates who focus on trauma services, safety planning, shelter and advocacy such as domestic violence and/or sexual assault; (6) legal system responders such as prosecutors, elder law and public interest attorneys and court personnel; (7) ombudsmen who advocate for persons in long-term care residential facilities by resolving complaints about and promoting resident health, safety, well-being and rights; (8) financial services industry entities, such as banks and brokers; and (9) members of the faith community. Some potential responders, like APS, respond to elder abuse daily. Yet most cases are not reported to the entities designated to address elder abuse. For every one case that comes to light, another 23 remain hidden.²² Individuals who do not specialize and are not trained in elder abuse issues (e.g., police officers, bank tellers, letter carriers, or clergy) may be the only ones in a position to notice that abuse may be occurring. Whatever their role, they are potential allies whose involvement is critical to an informed approach to prevention, detection, reporting, and response. The following priorities apply to all potential responders who interact with older people and who may be in a position to prevent, report or respond to suspected elder abuse:

- **Caregiving workforce:** Develop ways to better enlarge the caregiving workforce – paid and unpaid – to promote and support good care in home, community, and facility settings. Ensure adequate pay, benefits, and working conditions for paid caregivers. And, for all caregivers, assure quality training on caregiving and elder abuse.
- **Care/case management:** Increase the availability of community care coordinators and case managers trained to recognize risk factors, respond to elder abuse, and aid clients in prevention and risk reduction.
- **Cultural capacity:** Ensure that practitioners know how to identify and respond to the unique attributes of elder abuse as they relate to factors such as age, incapacity, disability, ethnicity, family structure, language, gender, national origin, race, religion, sexual orientation, and socioeconomic status.
- **Funding:** Increase resources for practitioners who work to prevent elder abuse and

respond to the needs of victims.

- **Gap analysis:** Identify and address gaps in services across networks to improve prevention of elder abuse, neglect, and exploitation – including aging, consumer, disability, legal, financial, health, hotline, housing, mental health, social, trauma, or victim services.
- **Geriatric experts:** Develop more health professionals with expertise in aging and elder abuse by providing additional training to existing professionals and recruiting students into the field. Such professionals also should learn about local multidisciplinary teams that address legal, social service, or financial issues, and, where appropriate, participate in such teams. Training for some also should include cross-training in geriatrics and forensic pathology. These experts need to know how to detect suspicious signs and report elder abuse cases (when appropriate) so that they can assist older adults to prevent, ameliorate, or end elder abuse.
- **Justice system and legal responses to elder abuse:**
 - Create law enforcement and prosecution units that specialize in elder abuse, and enhance involvement of Medicaid Fraud Control Units and State Attorney General Offices in elder justice cases, such as those involving abuse and neglect in long-term care.
 - Educate court personnel about the needs of elder abuse victims so that they can knowledgeably handle elder abuse cases and accommodate older people's needs.
 - Educate civil attorneys about the needs of elder abuse victims and their critical role in identifying and responding to these cases.
 - Multidisciplinary responses: Develop and support multidisciplinary responses to elder abuse. Encourage participants involved in multidisciplinary teams to collect data about their practice and to describe their successes and challenges in ways that can inform others engaged in similar efforts.
 - Partnerships with related fields: Develop collaborations between the elder justice field and other allied fields involved with older adults, including aging, caregiving, civil, legal, domestic violence and sexual assault, mental health, substance abuse, and trauma.

Education Priorities

Without raising public awareness, millions of older people and the people who care about and for them will be unaware of ways to prevent elder abuse in their lives and how to identify or address it if it does occur. Without training and education, first responders and service providers in numerous fields – many of whom are natural allies for the elder abuse field – will lack the skills they need to prevent, identify, report, or address elder abuse. Education and training are needed within individual professions, agencies, disciplines, and in multidisciplinary settings that bring together diverse responders. In addition, where research has identified critical knowledge, it should be disseminated to the field. The same is true of programs, policies, and procedures that have demonstrated effectiveness in combating elder abuse. For all of these reasons, participants in this project identified a number of priorities relating to education, training, and raising awareness, including:

- **Awareness about cultural competence:** Work with grassroots organizations and leaders from underrepresented and underserved populations to ensure that public awareness and consciousness raising efforts are tailored to their realities of elder abuse and the media outlets that reach them, and that they contain messages specific to their perceptions and needs.
- **Culture change:** Assure that long-term care providers at all levels are trained in progressive and innovative models of person-centered long-term care. Ensure that those models are responsive to consumer preferences and respectful of caregivers.
- **National training plan:** Create and implement a national elder abuse education and

training strategic plan by identifying existing curricula and training materials, evaluating those materials, creating new quality materials to fill existing gaps, pilot testing and evaluating those materials, and disseminating the materials to the field. Ensure that older adults and persons from diverse communities are involved in the development and delivery of materials. Ensure that, where appropriate, curricula and programs are culturally competent.

● Populations and disciplines that need training and education: Train people in a position to prevent, recognize, and respond to elder abuse – whether it is a core aspect of their lives or work or whether they are natural allies. Those who require training include the following:

- Aging services network personnel and volunteers.
- Caregivers (both informal and formal) to build resiliency and protective factors using model programs, such as home visits used in the child abuse field.
- Care managers (including in managed care and long-term supports and services systems).
- Health care workers such as doctors, nurses, nursing assistants, dentists, and rehabilitation staff that work with patients short-term, acute, or emergency department settings, as well as in long-term care facilities.
- Faith leaders.
- Financial services industry personnel.
- Forensic experts to aide in the detection, analysis, investigation, and prosecution of elder abuse cases.
- Individuals working with persons with disabilities.
- Individuals working in the elder abuse field at the local, state, and national levels (discipline-specific and multidisciplinary).
- Individuals who come into contact with older people (such as postal workers, home delivered meals staff, and volunteers, etc.) on how to recognize, respond to and refer suspected elder abuse.
- Justice and legal system personnel including civil and elder law attorneys, law enforcement, prosecutors, investigators, coroners, and medical examiners.
- Mental health service providers, including employee assistance programs.
- Substance abuse program providers.
- Victim services providers.

● **Public awareness:** Work with experts in communication and media to create a strategy to raise consciousness and public awareness about elder abuse. Decide on the goals for such a campaign, including who to target and what messages will most effectively reach them, and impart the desired information.

● **Spokespersons:** Expand the cadre of skilled spokespersons who can articulately and accurately communicate compelling messages about elder abuse and raise awareness and consciousness at local, state, and national levels. (See also “Public awareness”.)

● **Trainers/educators:** Expand the cadre of individuals in all sectors who can provide quality training and technical assistance relating to elder abuse at the local, state, and national levels. We need more trainers to provide both discipline-specific and multidisciplinary training and technical assistance. “As a preventive measure, people can become better prepared. We do a lot to prepare people to become parents of children but little to prepare children to care for parents in their old age.” – leadership interview

Policy Priorities

● **Infrastructure:** Develop infrastructure to promote consistency, coordination, efficiency,

and focus in policy-development, practice, research, and training at the federal, state, and local levels, for example:

- **Federal Offices:**
 - Federal Office(s) of Elder Justice, comparable to federal offices at DOJ and HHS that address child abuse and domestic violence.
- **Resource centers:** As exist in other fields, the elder justice field needs well-funded resource centers including:
 - One strong general resource center addressing many overarching issues (for example by enhancing resources to the National Center on Elder Abuse with resources comparable to those allocated to centers that address child abuse and domestic violence/violence against women).
 - Specialized resource centers such as for Adult Protective Services, Long-term care Ombudsman program, older victim services, legal services, and guardianship.
- **Long-term Care:** Strengthen monitoring of long-term services and supports (e.g., survey and certification systems), and examine policies to better prevent, detect, and redress abuse and neglect in home, community-based, and institutional long-term care settings, whether perpetrated by family members, staff, other residents, or others.
"You have to have a communication strategy that actually communicates with people, not just repeat your message over and over again, which is what some people think communication is, as opposed to really finding out what people are absorbing from the message you're sending."
– leadership interview Archstone Foundation
- **Medicare and Medicaid reimbursement policy:** Examine how Medicare and Medicaid policy could be modified to prevent and mitigate elder abuse, for example by reimbursing for actions designed to screen for, detect, intervene in, and prevent elder abuse.
- **Multidisciplinary efforts:** Cultivate and fund multidisciplinary efforts in elder abuse matters. Address impediments to coordination including confidentiality, privacy and other laws, regulations and protocols. Evaluate the efficacy of varying multidisciplinary models.
- **Political constituency:** Develop coordinated, well-funded advocacy entities and multidisciplinary networks to inform policy, increase resources, and raise awareness at the national, state, and local levels. These efforts should include cultivation of allies, political leaders, the private sector, and charitable foundations. In addition, these efforts should involve promoting public awareness that elder abuse is an issue for people of all ages.
- **Related fields:** The elder justice field should engage in and partner with a variety of overlapping fields (with their individual and organizational leaders alike) whose constituencies are affected by elder abuse. These partnerships should work toward greater integration of efforts, cross training, and joint initiatives targeting awareness, prevention, detection, intervention, and referrals. The related fields, issues, networks, and areas of interest identified by stakeholders as important for greater coordination with the elder justice field include the following:
 - Aging services network
 - Caregiving
 - Cognitive capacity
 - Disability rights
 - Domestic violence
 - Elder rights
 - Financial services
 - Justice system

- Law enforcement
 - Legal services
 - Mental health
 - Public health
 - Protective services
 - Research
 - Sexual assault
 - Victim services
 - **Transitions:** Identify and develop policy to respond to transitions that might heighten the risk of elder abuse, such as when an older adult goes from a rehabilitation facility or hospital to a home with inadequate care or when an inappropriate caregiver moves in with an older person. “There needs to be empowerment for the network. Nothing can be done in isolation; no one agency can provide all services. If a victim falls through the cracks, they receive services too late. So there needs to be leadership in the federal, state, and local networks to oversee how services are organized, funded, and supported.”
- facilitated discussion Yrchstone Foundation

Research Priorities

Experts generally agree that the knowledge base relating to elder abuse lags decades behind that of child abuse and domestic violence. The consequences of this deficit are not merely academic. It means that those on the front lines often are without the tools or resources to detect elder abuse or the most appropriate ways to respond to it. It also means that we know little about what language is effective in talking about the problem (with older people or the public) or what preventative measures are effective. In addition, older people and victims of elder abuse have not been asked in any systematic way what they consider to be successful outcomes of interventions. Their answers could and should inform all efforts. The experts who worked with the Elder Justice Roadmap Project point out that elder abuse will not stop while we wait for (often time-consuming) research to inform practice. Thus, in the interim, practitioners should proceed based on practice-based evidence of what is effective. But the need for more research is urgent and it is an area that calls out for a coordinated, systematic approach that includes policy-makers, researchers and funders. In addition, translating challenges faced by practitioners into research questions and translating the findings of researchers into usable forms for practitioners is critical. Researchers and practitioners need to work together in all phases of research, including identifying research questions, interpreting results, and disseminating information.

Research-related priorities identified in this project include the following:

- **Elder justice researchers:** Cultivate and mentor a cadre of elder justice researchers. The dearth of academic researchers studying elder abuse issues impedes knowledge development in the field. As a result, there are few data to inform and guide practitioners, policy-makers, and trainers. Such researchers also play important roles as thought leaders in the field.
- **Definitions:** Develop comprehensive, consistent definitions of elder abuse to be used in various contexts such as research, law, critical care, and services.
- **Standards and methods:** Evaluate and validate the standards and data collection methods currently employed by the field. Standards and data collection methods used by various entities (such as surveyors, adult protective services, long-term ombudsman, and others) are variable. Researchers should assist in developing the parameters and methods used to build an evidence base designed to collect accurate data and show the

impact of effective practices.

● **National research agenda:** Develop a focused research agenda to get the most information from limited funding. Priorities to consider include:

1. Cognitive Impairments

- Develop better instruments and methods to assess whether potential victims have cognitive impairments.
- Determine effective surveillance, intervention, and prevention strategies for victims with cognitive impairments in all settings – at home, in community-based care, and in institutional settings.
- Identify ways to measure the prevalence of elder abuse among people with dementia and other cognitive impairments. “It’s hard to make the case for resources without some good surveillance data. And, that’s been a huge handicap.” – leadership interview

2. Cost and Consequences

- Identify the costs and consequences of elder financial exploitation, such as the impact on health, financial well-being and risk for other types of elder abuse.
- Calculate the economic cost of other forms of elder abuse and neglect (e.g., facility placements, hospitalizations, trips to the emergency room, lost assets and wages, increased reliance on Medicaid and other public programs, etc.) to assist in identifying areas of costs savings from addressing the problem.
- Develop validated methods and tools to collect data from various systems that have data relevant to elder abuse, including APS, criminal justice, financial services, guardianship, health care, law enforcement, ombudsman, Social Security (representative payees), survey, and others.

3. Intervention and Prevention

- Determine what messages are effective in reaching critical audiences.
- Determine what causes elder abuse, determine what theoretical models explain it, and develop and evaluate interventions to test the theoretical models.
- Create partnerships between researchers, first responders, and other service providers who have experience working with older victims.
- Recruit researchers with expertise in studying prevention to the elder justice field.
- Evaluate the efficacy of programs designed to address elder abuse, such as adult protective services and long-term care ombudsman programs, and identify which models and practices are most effective.
- Determine how victims, potential victims, and their caring family and friends define successful interventions.
- Evaluate the availability of emergency/transitional housing and other victim service options for older victims. Evaluate existing services to determine which models best meet older victims’ needs and preferences.
- Create and test intervention strategies that are designed to enhance strengths and ameliorate risks for elder abuse.
- Evaluate the effectiveness of laws and legal interventions in preventing and stopping elder abuse.
- Test and evaluate the efficacy of various types of multidisciplinary responses to elder abuse to determine critical components and which models are most effective in which circumstances.

4. Law, Policy, and Protocol Evaluation

- Systemically evaluate existing laws and how (if at all) they are implemented.
- Draft model laws and policy to fill gaps in elder abuse prevention and response.

- Evaluate safety audits used in the domestic violence field to determine if a similar process might be useful in elder abuse interventions.
- Create demonstration projects that test criminal justice and civil legal interventions targeting abusers or individuals deemed high risk for abusing, neglecting, or financially exploiting older people.

5. Risk Factors and Forensic Markers

- Identify forensic markers to assist in the detection of elder abuse.
- Study neglect of older people, including risk factors (e.g., social isolation, loneliness, “unbefriended elders,” and poverty), and the assessment of and intervention in such situations.
- Conduct a long-term (longitudinal) study examining the characteristics of victims and/or perpetrators (such as substance abuse, mental illness) and contextual factors (such as poverty, isolation, dependence or disability, family violence) in elder abuse cases.
- Determine the rates of elder abuse by type of abuse, neglect, or exploitation and by type of perpetrators (including characteristics of long-term care providers).

6. National research centers: Create national research centers of excellence to coordinate and accelerate research, based on models from numerous other fields.

- Research Translation: Develop effective strategies to translate and disseminate information learned through research projects to the field, and translate questions faced by practitioners to researchers for study.
- Successful outcomes: Develop definitions for “success.” An ongoing impediment to effective interventions is that the elder justice field lacks a definition of what constitutes successful outcomes. There is no benchmark against which to measure the success of various efforts. A critical research priority is to define what constitutes successful outcomes in elder abuse interventions and prevention efforts. “Before we do research or data analysis, we’ve already thought through how it’s going to be used. We think through a larger communications, government affairs, field operations and dissemination strategy ahead of time to determine whether all the effort is going to be worth it to reach our objectives.” – leadership interview

D. Universal Themes that Cut Across Phases and Domains

The following themes and topics arose in all phases of the project and do not fit neatly into any one of the four domains: direct services, education, policy and research. Participants indicated that it is critical to be cognizant of these issues in all efforts to address and prevent elder abuse:

- Ageism: Confront ageism through education, training, and public outreach. By marginalizing older adults, our youth-oriented culture often ignores or fails to identify instances of elder abuse. Addressing ageism must be part of awareness and prevention strategies.
- Diversity and inclusion
- Awareness
- Economic motives
- Brain health and functioning consequences (of older people at risk)
- Knowledge development
- Brain health and functioning
- Long-term care (of potential perpetrators)
- Older peoples’ voices
- Caregiving (family; unpaid)
- Prevention

- Caregiving (paid; all settings)
- Resources
- Coordination
- Screening
- Multidisciplinary approaches
- Victim services
- Data collection and evaluation

Awareness: Create a compelling narrative for the field. We need to create narratives that articulate the depth and breadth of the problem, engage community members and professionals to respond effectively, clarify language used in connection with elder abuse, and provide accurate and useful information about how best to respond when elder abuse happens and how to prevent it in the first place.

Brain Health and Functioning of Potential Victims: Expand knowledge and improve integration of cognitive capacity and mental health issues as they relate to elder abuse. Many elder abuse victims have organic conditions, such as Alzheimer’s and other forms of dementia, brain injuries or developmental disabilities that lead to diminished or limited cognitive capacity. Older people with diminished capacity are more susceptible to abuse, neglect, and financial exploitation. Some older victims may experience mental health issues, such as depression and post-traumatic stress disorder – especially those who have experienced ongoing, long-term trauma related to the elder abuse. We need additional research to understand how to evaluate cognitive capacity and mental health issues within the context of elder abuse and how to protect and provide a range of effective services to those with cognitive impairments and/or mental health issues.

Brain Health and Functioning of Potential Perpetrators: Expand knowledge to inform policy and practice about the role of mental illness, substance abuse, intellectual disability, diminished capacity, and abuse history in potential perpetrators. Preliminary research indicates that intervention with potential perpetrators may be more effective than intervention with victims in preventing elder abuse.²³ Those on the front lines also have observed that many elder abuse perpetrators have mental illness, diminished capacity, or substance abuse problems. An additional complicating factor arises when, for example, an adult child who was previously abused by a parent becomes that parent’s caregiver. (A similar scenario also arises with abused partners becoming caregivers.)

Caregiving – by family and other informal caregivers: Consider and address the critical nexus between elder justice and informal caregiving. Stakeholders from family caregiving and elder justice fields rarely have focused on the common goals of their work, the difficult issue that some caregivers may be responsible for abuse, neglect, or exploitation, or how to raise awareness about and prevent such mistreatment. Few family caregivers receive the training or support they need.

Caregiving – by paid caregivers in any setting: Consider and address the critical nexus between elder justice and a paid caregiving workforce. Paid caregivers often receive insufficient training and support, raising the risk of poor care. In addition, although more people are receiving home and community-based care, such settings often lack protections and oversight, an important focus as increasing numbers of people become consumers of such care. To meet the demand of an aging population, there must be an expansion of the workforce

with caregivers who are adequately trained, supervised, overseen, and paid, and who, among other things, know how to prevent, identify, report, and respond to elder abuse.

Coordination and Multidisciplinary Approaches: Encourage coordination and the development of multidisciplinary approaches. Understanding and addressing elder abuse will require enhanced coordination among players with diverse expertise and formation of multidisciplinary teams and approaches in direct services, education, policy, and research. Such multidisciplinary approaches should also be evaluated to identify the most effective among them. “Some messages about elder abuse are offensive. We need to craft messages for caregivers that make them feel respected and help them to recognize, acknowledge, and prevent elder abuse, and learn what supports are available.” – facilitated discussion Archstone Foundation

Data Collection and Evaluation: Collect uniform national elder abuse data to inform efforts to prevent and respond to the problem. It is difficult to mount an effective response to a problem about which we know so little. The child abuse and domestic violence fields have collected data for decades that have revealed the nature and dimensions of those problems and informed and shaped more effective responses. However, federal law only began requiring the collection of elder abuse data in 2005. In 2013, both HHS and DOJ were engaged in complementary projects to begin collecting data on elder abuse reported to APS. Those projects are an important first step towards achieving a better understanding of elder abuse. But APS data are only a subset of all data relevant to elder abuse. (They do not include health, law enforcement, financial, or medical examiner data, for example.) And collecting pilot data is a first step to nationwide data collection. Comprehensive data collection is critical to inform efforts to detect, respond to, and prevent elder abuse, to shape policy, and to allocate resources where they’re most needed. “I don’t think elder abuse is perceived as an issue by a lot of people. Even though there’s clearly underreporting of child maltreatment, it’s still perceived as an issue. People know that it happens and feel some sense of obligation to report it, at least some circumstances. People see elder abuse as a problem, nor understand the importance of reporting. So we don’t even have mediocre data.” – leadership interview Diversity and Inclusion of Underrepresented and Underserved Populations: Address and integrate the unique needs of older people related to race, ethnicity, gender, age, national origin, language, literacy, disability, religion, sexual orientation, socio-economic status, and family structures. The experience and context of elder abuse may differ based on the identities – cultural, ethnic, gender, racial, religious, sexual orientation, etc. – of both victim and abuser – and awareness and respect for these diverse identities must be integrated into all aspects of elder abuse work. As the field grows, professionals and programs must ensure that their reach – in services, education, policy-making, data collection, and research – extends to and includes traditionally underrepresented and underserved populations.

Economic Motivations and Consequences: Investigate the many economic causes and consequences of elder abuse. Many elder abuse cases are financially motivated, and financial exploitation and other types of elder abuse often occur in the same case. We are learning more about financial capacity, especially in mild cognitive impairment, and how it makes older people much more vulnerable to mistreatment. The financial services industry and public agencies addressing economic issues and consumer protection have interests in addressing financial exploitation, and these efforts should be coordinated.

Prevention: Develop knowledge and initiatives regarding prevention of elder abuse. The field

would benefit from studying what has worked in other fields and working with prevention experts on issues such as child abuse, domestic violence, sexual assault, smoking, and traffic safety (e.g., seat belt use and drunk driving).

Resources: Increase the allocation of resources to the field of elder abuse. Every aspect of elder abuse research, policy, practice, and training is undermined by a dire and chronic dearth of resources. Existing federal laws should be fully funded and other public and private funders must allocate resources to this problem if we are to implement the policy, practice, research, and training priorities described in this document. “We know a whole range of risk factors for child maltreatment, from economic to social and environmental issues to childcare, to support services.... There are incredible opportunities for primary prevention in elder abuse. But you have to start thinking – what are the risk factors? What are the precursors? What can you do to influence individual behavior? What can you do to create a social environment that has a prevention quality to it? What kind of services can you create for elders that diffuse or reduce stress levels of caretakers? And, what can you do with health care providers to maximize cognitive ability for as long as possible? All of those kinds of things are linked to preventing elder abuse....” The ability to support safety, to enhance nurturing, to teach nurturing skills, to promote connectedness, all of that kind of stuff mediates risk and creates protective factors.” – leadership interview Yves Picq

Screening: Improve the practice of and tools used in screening for elder abuse. To prevent ongoing abuse and ameliorate current suffering, we need to increase our ability to identify and detect elder abuse, both at the population level and also in one-on-one interactions between older people and direct service providers and first responders. This requires research to validate screening tools for different settings, training of professionals in how to use them and policy initiatives promoting screening when appropriate. Factors such as privacy, confidentiality, mandatory reporting, cognitive capacity, setting, training needs, and cultural variation should be taken into consideration in the development and use of screening tools. Improved screening will identify increased numbers of victims whose needs will only be met if additional resources are allocated. Identifying more victims but then not serving their needs poses complex ethical dilemmas that should be thoughtfully addressed but not serve as an impediment to improving screening practices.

Victim Services: Evaluate existing victim services for best practices and pilot additional services to address the specific needs of older victims; integrate best practices into all services. Core services designed to reach out to and address trauma, safety and the specific needs of older victims are integral. Existing, ongoing services should be evaluated and modified to reflect best practices in serving older victims. New pilots should be developed to identify ways to most effectively serve older victims. Policies are needed to ensure that victim services are provided to older adults. Training for service providers is needed to address the unique needs of older victims. Older adults also require certain services that are not designed specifically for elder abuse victims (e.g., transportation, home delivered meals, victim advocates in the court, prosecution, and law enforcement systems, etc.). “Look for natural allies outside the field: financial institutions, criminal justice, long-term care, housing, the aging network, victim services. Often they know it’s an issue but not how to get involved.” – leadership interview Gina Bower Photography

NEXT STEPS AND CONCLUSION

The diverse subject matter experts who participated in this project found the meetings and calls

to be so valuable that they decided to continue working together, as an initial matter on dissemination of this document and furthering implementation of the priorities identified in this project. To that end, they designated a provisional Elder Justice Roadmap Steering Committee. Other ongoing goals include: continuing and coordinating the implementation work; reaching out to policy-makers, funders and others to explore ways to further the priorities identified in this document; and fostering ongoing communication on these issues. “To the extent that things happen at different levels – federal, state, local, and so on, it seems to me that consciousness-raising is a top priority at this juncture because this issue is not on the radar of most people. But given that it’s an aging society, there will be more of this. It’s really worth doing but requires staff.” – leadership interview Microsoft

Conclusion

The Elder Justice Roadmap is a groundbreaking partnership – among those who work primarily to address elder abuse and critical allies in related fields – to apply a wider lens to elder abuse in drafting this first national strategic plan for elder justice. This document reflects priorities that hundreds of practitioners identified as important and leading experts deemed critical and attainable. All participants in this project recognize that the priorities listed above are not the only important ones. All 121 ideas offered by stakeholders are listed in Appendix D for those wishing to use this document to inform their own priority-setting, action planning, and implementation efforts to reduce the blight of elder abuse through efforts at the local, state, and national levels. Elder abuse is a problem with solutions – some complex and others simple and within reach. The vast suffering, cost, and dislocation caused by elder abuse demand a commensurate investment of resources and attention. This project steers a course toward a long-needed strategic approach to reducing elder abuse. There is a role for everyone. The time to act is now.

After studying many options, the following definition of elder abuse was used for this project: Elder abuse is – physical, sexual, or psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity, that occurs in any setting (e.g., home, community, or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability.

The reasons for using this definition/description fall into several categories:

Age: We used the term “older person” rather than designating a specific age because we did not want to limit stakeholders’ responses. By not specifying a precise age, participants could respond regardless of the age used in the laws or protocols governing their state, tribe, agency, or program.

Younger vulnerable adults: Some definitions of elder abuse include abuse not only of older people but also of younger vulnerable adults ages 18 to 60 (or 18 to 65, depending on the jurisdiction). It is conceptually confusing and factually inaccurate to say that the abuse of younger adults, such as a person age 18, constitutes elder abuse. Although similar and overlapping issues often relate to both older adults and younger people (usually described in laws as “vulnerable” or “adults with disabilities”) who are victimized, there may also be significant differences. For the purposes of this project, we believed it was important not to conflate those populations or assume that the needs, wishes, priorities, and considerations relating to older and younger victimized people were the same. That said, critical players in the elder abuse field – such as some Adult Protective Services, long term care ombudsman programs, and health providers, as well as the Administration for Community Living – have

missions, jurisdictions, clients, and patients that include all adults, regardless of age. We recognize the overlap in the issues facing older and younger populations, that there often is good reason to provide seamless services across ages, and that those who serve both populations should not be forced to choose between them, for example, by conditioning resources on age.

Types of abuse: In developing the definition of elder abuse for this project, we used broad terms that describe the types of abuse older people experience (e.g., physical, sexual, or psychological abuse, financial exploitation, neglect). Though abandonment is a form of neglect, we also included it because some states refer to it separately in their elder abuse laws.

Self-neglect: Though some definitions of elder abuse include self-neglect we did not because conceptually, one person being mistreated by another is fundamentally a different type of phenomenon than a person neglecting him or herself. Conflating abuse, neglect, or exploitation that one actor inflicts on another with situations involving a sole actor is confusing and counter-intuitive to many stakeholders. That said, self-neglect (like mental illness and cognitive impairment) often is associated with elder abuse (including as a potential risk factor or consequence) and thus is a critical factor to consider in any discussion about the problem. In addition, some agencies that respond to allegations of elder abuse also provide services to individuals who neglect themselves.

Relationship of trust: Some definitions of elder abuse have required that the perpetrator be someone in a “relationship of trust” with the victim. This excludes older people victimized wholly or in part because of their actual or perceived age or disability where the victimization did not occur in a relationship of trust. The definition in this project included older people targeted based on their age or disability even where no relationship of trust exists. We used this broader definition in part to not exclude a range of stakeholders whose role is not conditioned on a relationship of trust, for example those responding to financial exploitation and consumer protection issues. Additional discussion is needed to address how responders can or should determine whether a relationship of trust exists or targeting has occurred.

Setting: When elder abuse occurs, victims suffer regardless of setting of the mistreatment, identity of perpetrator, or the professionals and entities with jurisdiction or responsibility to respond. Inadequate response or coordination among responders, or during transitions from one setting to another, can exacerbate vulnerability to and duration of elder abuse. In addition, given the emphasis on providing care, services, and assistance in a person-centered manner, it is increasingly important to have definitions of abuse, neglect, and exploitation that apply across settings (home, community, and facilities). Thus, for this project, we did not limit the definition of elder abuse to any one setting.

Entities as perpetrators: Elder abuse can be perpetrated by entities such as long-term care institutions, fraudulent financial organizations, corporations, and others. Abuse in these cases may be deliberate (e.g., scams targeting older clients or long-term care entities that knowingly siphon off funds intended for resident care), or it may occur as a result of an entity failing to affirmatively act to protect the safety of older adults and their assets.

Definition versus description: Individuals, entities, and documents use different definitions of elder abuse depending on discipline and context. For example, a definition of elder abuse for purposes of a criminal law might include the concept of knowledge or intent. Our aim in this project was to employ a definition that described the core conduct included in elder abuse so that it could be used in various contexts and by people in many applicable disciplines, understanding that additional specification might be necessary in some applications.

In developing the definition used in this project, we considered and built on many of the varied existing definitions, including: those found in laws (such as the federal Elder Justice Act, Older

Americans Act, and Violence Against Women Act, various states' laws, and others), and those developed by various entities such as the National Academy of Sciences, the Administration on Aging (through the National Center on Elder Abuse), the Centers for Disease Control and Prevention (not publicly released or in use), and the New York City Elder Abuse Center (a definition rigorously vetted by a broad range of stakeholders and that, subjected to the crucible of daily application by myriad systems for three years, has held up well).

9. Additional State and National Resources

Please find all of the following links at the National Center for Elder Abuse here <http://www.centeronelderabuse.org/resources.asp>

Government

Administration on Aging (AoA) on Elder Rights and Resources
Administration on Aging Strategic Action Plan 2007-2012 (PDF) April 2007
Clearinghouse on Abuse and Neglect of the Elderly (NCEA)
Consumer Finance Protection Bureau
National Long Term Care Ombudsman Resource Center (NORC)
National Adult Protective Services Association (NAPSA)
National Association of States United for Aging and Disabilities (NASUA)
National Center on Elder Abuse (NCEA)
Office for Victims of Crime (OVC)
Office on Violence Against Women (OVW)

State

California State and Local Resources »
Bureau of Medi-Cal Fraud and Elder Abuse
Medi-Cal Fraud and Elder Abuse Statutes
Department of Aging
Long-Term Ombudsman Program
Adult Protective Services offices
California Commission on Aging

Directory of Regional Centers (Department of Developmental Services)

Adult Protective Services Training Academy: Bay Area Academy
Archstone Foundation Elder Abuse & Neglect
California Social Work Education Center (CalSWEC) Aging Initiative
California Elder Justice Coalition (click CEJC)
California Council on Geriatrics and Gerontology (CCGG)
Archstone Foundation Fault Lines in the Shifting Landscape: The Future of Growing Older in California 2010
California Association of Area Agencies on Aging (C4A)
California Caregiver Resource Centers
California District Attorneys Association
California Foundation of Independent Living Centers

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