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Aging and Elder/ Dependent Abuse Assessment and Reporting Course- 10 Hours/Units



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Objectives

This course is designed to help you:

1. Explain at least two types of elder/dependent physical abuse.
2. Discuss at least two types of elder/dependent financial abuse.
3. Explain at least two elder abuse warning signs for physical abuse.
4. Discuss at least two elder abuse warning signs for financial abuse.
5. Describe at least two elder abuse warning signs for neglect.
6. Explain at least one clinical and/or legal response to suspected elder and dependent abuse.
7. Describe at least two screening and assessment tools for identifying suspected elder and/or dependent abuse.
8. Discuss at least one mandatory reporting guideline and/or requirement.
9. Identify at least two relevant elder and dependent abuse resources.
10. Explain at least one high risk factor for intimate partner or domestic violence later in life

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1. Detecting Elder Abuse And Neglect: Assessment And Intervention

Elder and Dependent Adult Abuse Defined

The World Health Organization

Worldwide, there is controversy around the term “elder abuse”. Other terms often used include “elder mistreatment” and “inadequate care of the elderly”. Consequently, there is no global consensus as to how to define elder abuse. Lack of agreed definitions reflects the different theories on which elder abuse definitions and interventions have been based over the past 25 years.

Although there is no global consensus on a definition, most literature so far attributes to elder abuse five types or categories: physical, psychological/emotional, financial, sexual, and neglect. Some literature also includes as a category violation of rights, denying an older person rights conferred on her/him by law or legal process. Each type of abuse may occur singly or in combination, and in a range of settings, such as people’s own homes, where the vast majority of older people live, day centers, hospitals and nursing homes.

Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical,

sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.

The United States

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.

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), 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. 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. 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.

The Need for Uniform Definitions

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.

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. 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.

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

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 in 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. 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)
- ◆ 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.
- ◆ 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.

Additional Definitions and 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.

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.”

Federal 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.)

California law says elder or dependent adult abuse is:

- ✓ Physical abuse, sexual abuse, neglect, financial abuse, abandonment, isolation, abduction (taking the person out of the state against his or her will), or other behavior that causes physical harm, pain, or mental suffering; and/or
- ✓ Deprivation by a caregiver of things or services that the elder or dependent adult needs to avoid physical harm or mental suffering.

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.

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.

More On 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.

“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.

2. Elder Abuse and Adult Protective Services

Older people are the fastest growing segment of the population world-wide. Globally, the number of persons aged 60 years or over is expected to almost triple within the next few decades, to nearly 1.9 billion by 2050. The very old group – aged 80 and over – who are at special risk of being abused, will increase even faster.

Elder abuse, like other types of interpersonal violence, remained hidden and taboo throughout history. It was after child abuse and domestic violence began to be discussed publicly in the 60s and 70s that elder abuse, which initially was called “granny battering”, emerged as a form of family violence. While the abuse of older people was first described in British scientific journals in 1975, scientific and legal action was, and by large, first developed in the United States of America. In 1990, the first, and to date only, prevalence study on elder abuse was published in the United Kingdom. Elder abuse, a very complex issue with diverse definitions and names, has been very slow to capture the public eye and public policy. Since it is manifested at many levels (physical, psychological, legal, social), it requires the involvement of different types of professionals.

Key Facts

- ★ Around 1 in 6 people 60 years and older have experienced some form of abuse in community settings during the past year.
- ★ Rates of elder abuse are high in institutions such as nursing homes and long-term care facilities, with 2 in 3 staff reporting that they have committed abuse in the past year.
- ★ Elder abuse can lead to serious physical injuries and long-term psychological consequences.
- ★ Elder abuse is predicted to increase as many countries are experiencing rapidly aging populations.
- ★ The global population of people aged 60 years and older will more than double, from 900 million to about 2 billion in 2050.

Scope of the problem

Elder abuse is an important public health problem. A study based on the best available evidence from 52 studies in 28 countries from diverse regions, including 12 low and middle-income countries, estimated that, over the past year, 15.7% of people aged 60 years and older were subjected to some form of abuse (1).

This is likely to be an underestimation, as only 1 in 24 cases of elder abuse is reported, in part because older people are often afraid to report cases of abuse to family, friends, or to the

authorities. Consequently, any prevalence rates are likely to be underestimated. Although rigorous data are limited, the study provides prevalence estimates, drawing on all available studies, of the number of older people affected by different types of abuse.

Data on the extent of the problem in institutions such as hospitals, nursing homes, and other long-term care facilities are scarce. However, systematic reviews and meta-analyses of recent studies on elder abuse in both institutional and community settings based on self-report by older adults suggests that the rates of abuse are much higher in institutions than in community settings.

Estimates of elder abuse and its subtypes in the institutions were calculated from all studies that collected data from staff as well as older adults and their proxies. A total of 9 studies in 6 countries based on staff self-reports on perpetrating abuse were analyzed together. The finding indicates that 64.2% of staff perpetrated some form of abuse in the past year. The self-reported estimates of elder abuse subtypes by staff and older residents suggest similarities in the magnitudes of the problem.

Abusive acts in institutions may include physically restraining patients, depriving them of dignity (for instance, by leaving them in soiled clothes) and choice over daily affairs; intentionally providing insufficient care (such as allowing them to develop pressure sores); over- and under-medicating and withholding medication from patients; and emotional neglect and abuse.

Elder abuse can lead to physical injuries – ranging from minor scratches and bruises to broken bones and disabling injuries – and serious, sometimes long-lasting, psychological consequences, including depression and anxiety. For older people, the consequences of abuse can be especially serious and convalescence longer. Even relatively minor injuries can cause serious and permanent damage, or even death. A 13-year follow-up study found that victims of elder abuse are twice more likely to die prematurely than people who are not victims of elder abuse.

Globally, the number of cases of elder abuse is projected to increase as many countries have rapidly aging populations whose needs may not be fully met due to resource constraints. It is predicted that by the year 2050, the global population of people aged 60 years and older will more than double, from 900 million in 2015 to about 2 billion, with the vast majority of older people living in low- and middle-income countries. If the proportion of elder abuse victims remains constant, the number of victims will increase rapidly due to population ageing, growing to 320 million victims by 2050.

Risk factors

Risk factors that may increase the potential for abuse of an older person can be identified at individual, relationship, community, and socio-cultural levels.

Individual

Risks at the individual level include poor physical and mental health of the victim, and mental disorders and alcohol and substance abuse in the abuser. Other individual-level factors which may increase the risk of abuse include the gender of victim and a shared living situation. While older men have the same risk of abuse as women, in some cultures where women have inferior social status, elderly women are at higher risk of neglect and financial abuse (such as seizing their property) when they are widowed. Women may also be at higher risk of more persistent and severe forms of abuse and injury.

Relationship

A shared living situation is a risk factor for elder abuse. It is not yet clear whether spouses or adult children of older people are more likely to perpetrate abuse. An abuser's dependency on the older person (often financial) also increases the risk of abuse. In some cases, a long history of poor family relationships may worsen as a result of stress when the older person becomes more care dependent. Finally, as more women enter the workforce and have less spare time, caring for older relatives becomes a greater burden, increasing the risk of abuse.

Community

Social isolation of caregivers and older persons, and the ensuing lack of social support, is a significant risk factor for elder abuse by caregivers. Many elderly people are isolated because of loss of physical or mental capacity, or through the loss of friends and family members.

Socio-cultural

Socio-cultural factors that may affect the risk of elder abuse include:

- ✓ Ageist stereotypes where older adults are depicted as frail, weak and dependent;
- ✓ Erosion of the bonds between generations of a family;
- ✓ Systems of inheritance and land rights, affecting the distribution of power and material goods within families;
- ✓ Migration of young couples, leaving older parents alone in societies where older people were traditionally cared for by their offspring; and
- ✓ Lack of funds to pay for care.

Within institutions, abuse is more likely to occur where:

- ✓ Standards for health care, welfare services, and care facilities for elder persons are low;
- ✓ Staff are poorly trained, remunerated, and overworked;
- ✓ The physical environment is deficient; and
- ✓ Policies operate in the interests of the institution rather than the residents.

Prevention

Many strategies have been implemented to prevent elder abuse and to take action against it and mitigate its consequences. Interventions that have been implemented – mainly in high-income countries – to prevent abuse include:

- ✓ Public and professional awareness campaigns
- ✓ Screening (of potential victims and abusers)
- ✓ School-based intergenerational programs
- ✓ Caregiver support interventions (including stress management and respite care)
- ✓ Residential care policies to define and improve standards of care
- ✓ Caregiver training on dementia.

Efforts to respond to and prevent further abuse include interventions such as:

- ✓ Mandatory reporting of abuse to authorities
- ✓ Self-help groups
- ✓ Safe-houses and emergency shelters
- ✓ Programs for perpetrators
- ✓ Helplines to provide information and referrals
- ✓ Caregiver support interventions.

Evidence for the effectiveness of most of these interventions is limited at present. However, caregiver support after abuse has occurred reduces the likelihood of its reoccurrence and school-based intergeneration programs (to decrease negative societal attitudes and stereotypes towards older people) have shown some promise, as have caregiver support to prevent elder abuse before it occurs and professional awareness of the problem. Evidence suggests that adult protective services and home visitation by police and social workers for victims of elder abuse may in fact have adverse consequences, increasing elder abuse.

Multiple sectors and interdisciplinary collaboration can contribute to reducing elder abuse, including:

- ➔ The social welfare sector (through the provision of legal, financial, and housing support);
- ➔ The education sector (through public education and awareness campaigns); and
- ➔ The health sector (through the detection and treatment of victims by primary health care workers).

In some countries, the health sector has taken a leading role in raising public concern about elder abuse, while in others the social welfare sector has taken the lead.

Globally, too little is known about elder abuse and how to prevent it, particularly in developing countries. The scope and nature of the problem is only beginning to be delineated. Many risk factors remain contested, and the consequences and evidence for what works to prevent elder abuse is limited.

WHO Response

The World Health Assembly recently adopted a global strategy and action plan on aging and health that provides guidance for coordinated action in countries on elder abuse that aligns with the Sustainable Development Goals.

In line with the global strategy WHO and partners collaborate to prevent elder abuse through initiatives that help to identify, quantify, and respond to the problem, including:

- ★ Building evidence on the scope and types of elder abuse in different settings (to understand the magnitude and nature of the problem at the global level), particularly in low- and middle-income countries from Southeast Asia, the Middle East, and Africa, for which there is little data;
- ★ Collecting evidence and developing guidance for Member States and all relevant sectors to prevent elder abuse and strengthen their responses to it;
- ★ Disseminating information to countries and supporting national efforts to prevent elder abuse; and
- ★ Collaborating with international agencies and organizations to deter the problem globally.

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.

Obvious Symptoms and Protective Services

Obvious symptoms include 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.

Additional 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

APS Facts and Figures

- ✓ 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

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.

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.

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.

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: anti-depressant medications; addressing their self-neglect; development of a support system. 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.

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.

Dementia and Alzheimer's Disease

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.

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.

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. 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 helping the client find the most effective drug with their provider.
- * 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. Arrangements for outpatient benefits (e.g., Medicaid) include an appropriate living situation and psychiatric aftercare.
- * Support 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.

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.

Caregiver Support

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)

3. Elder Abuse Assessment and Reporting

Throughout the past three decades, significant progress has been made in increasing the awareness of abusive relationships. Nonetheless, child abuse and intimate partner 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. Providers are in a unique position to affect diagnosis and management of this vulnerable population. The American Medical Association has recommended that 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

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.

Elder Abuse Assessment and Reporting

Mandated Reporters

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.

Who is required to report?

- Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults;
- Any elder or dependent adult care custodian;
- A health practitioner including a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, registered nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage and family, therapist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage and family therapist intern, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage and family therapist intern registered under Section 4980.44 of the Business and Professions Code, a clinical counselor trainee (as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code), a clinical counselor intern registered under Section 4999.42 of the Business and Professions Code, a state or county public health or social service employee who treats an elder or a dependent adult for any condition, a coroner, or a substance use disorder counselor.
- As used in this section, a “substance use disorder counselor” is a person providing counseling services in an alcoholism or drug abuse recovery and treatment program licensed, certified, or funded under Part 2 (commencing with Section 11760) of Division 10.5 of the Health and Safety Code.

- A clergy member including a priest, minister, rabbi, religious practitioner, or similar functionary of a church, synagogue, temple, mosque, or recognized religious denomination or organization, but excluding any unpaid volunteers whose principal occupation or vocation does not involve active or ordained ministry in a church, synagogue, temple, mosque, or recognized religious denomination or organization, and who periodically visit elder or dependent adults on behalf of that church, synagogue, temple, mosque, or recognized religious denomination or organization.
- An employee of a county adult protective services agency or a local law enforcement agency;
- All officers and employees of financial institutions are mandated reporters of suspected financial abuse; and
- Any notary public who, in connection with providing notary services, has observed or has knowledge of suspected financial abuse of an elder or dependent adult is a mandatory reporter of suspected financial abuse.

When is a report required?

When a mandated reporter, in his or her professional capacity, or within the scope of his or her employment:

- Has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect;
- Is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect; or reasonably suspects that abuse.
- When a mandated reporter of suspected financial abuse, who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records or transactions, and who within the scope of his or her employment or professional practice:
 - Has observed or has knowledge of an incident that is directly related to the transaction or matter that is within the scope of employment and reasonably appears to be financial abuse; or reasonably suspects that abuse.

Where does it go?

If physical abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center,

- ➡ If the suspected abuse results in serious bodily injury, an oral report by telephone shall be made to the local law enforcement agency immediately (and in no event later than 2 hours after the suspected abuse), and a written report shall be made to the local law enforcement

agency, the local ombudsperson and the corresponding licensing agency within 2 hours after the suspected abuse;

- ➡ If the suspected abuse does not result in serious bodily injury, then an oral report by telephone shall be made to the local law enforcement agency within 24 hours after the suspected abuse and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 24 hours after the abuse; and
- ➡ If the suspected abuse is caused by a resident with a physician's diagnosis of dementia and there is no serious bodily injury, the reporter shall report to the local ombudsperson or law enforcement agency by telephone immediately or as soon as reasonably practicable and by written report within 24 hours.

If other-than-physical abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the telephone and written report shall be made to the local ombudsman or the local law enforcement agency.

If the abuse occurred in a state mental hospital or a state developmental center and the alleged abuse or neglect resulted in death, sexual assault, an assault with a deadly weapon by a nonresident of a state mental hospital or a state developmental center, an assault with force likely to produce great bodily injury, an injury to the genitals where the cause is undetermined or a broken bone where the cause of the break is undetermined, then the report shall be made immediately (but in any event within 2 hours of the event) to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services and also to the local law enforcement agency.

Reports of all other suspected cases of abuse or neglect occurring in a state mental hospital or a state development center shall be made to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services or the local law enforcement agency.

Reports related to suspected abuse or neglect that occurred in any place other than a long-term care facility, a state mental hospital or a state developmental center shall be made to the adult protective services agency or the local law enforcement agency.

What definitions are important to know?

“Abandonment” means the desertion or willful forsaking of an elder or a dependent 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” means the removal from the State of California and the restraint from returning to the State of California, or the restraint from returning to the State of California, of any elder or dependent adult who does not have the capacity to consent to the removal from the State of California and the restraint from returning to the State of California, or the restraint from returning to the State of California, as well as the removal from the State of California or the

restraint from returning to the State of California, of any conservatee without the consent of the conservator or the court.

“Abuse of an elder or a dependent adult” means either of the following:

- Physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.
- The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.
- Financial abuse.

“Dependent adult” means:

- A person, regardless of whether the person lives independently, between the ages of 18 and 64 years who resides in California and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age; and
- any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility.

“Elder” means any person residing in California, 65 years of age or older.

“Financial Abuse” of an elder or dependent adult occurs when a person or entity does any of the following:

- Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both;
- Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or
- Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence.

A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.

For purposes of this section, “representative” means a person or entity that is either of the following:

A conservator, trustee, or other representative of the estate of an elder or dependent adult; or

An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

“Isolation” means any of the following:

- Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls;
- Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor, where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons;
- False imprisonment (as defined in the Penal Code); or
- Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors.

“Neglect” means either of the following:

- The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or
- The negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.

“Neglect” includes, but is not limited to, all of the following:

- Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.
- Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.
- Failure to protect from health and safety hazards.
- Failure to prevent malnutrition or dehydration.
- Failure of an elder or dependent adult to satisfy the needs specified above for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

“Physical abuse” means any of the following:

- Assault (as defined in the Penal Code);
- Battery (as defined in the Penal Code);
- Assault with a deadly weapon or force likely to produce great bodily injury (as defined in the Penal Code);
- Unreasonable physical constraint, or prolonged or continual deprivation of food or water;
- Sexual assault; or

- Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
 1. for punishment;
 2. for a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or
 3. for any purpose not authorized by the physician and surgeon.

“Reasonable suspicion” means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.

“Sexual Assault” means:

- Sexual battery (as defined in the Penal Code);
- Rape (as defined in the Penal Code);
- Rape in concert (as defined in the Penal Code);
- Spousal rape (as defined in the Penal Code);
- Incest (as defined in the Penal Code);
- Sodomy (as defined in the Penal Code);
- Oral copulation (as defined in the Penal Code);
- Sexual penetration (as defined in the Penal Code); or
- Lewd or lascivious acts (as defined in the Penal Code).

What timing and procedural requirements apply to reports?

- A telephone report or confidential Internet reporting tool report shall be made immediately or as soon as practicably possible.
- If the initial report was made by telephone, a written report must be sent, or an Internet report shall be made, within 2 working days.
- If physical abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center,
- If the suspected abuse results in serious bodily injury: An oral report by telephone shall be made to the local law enforcement agency immediately (and in no event later than 2 hours after the suspected abuse), and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 2 hours after the suspected abuse;
- If the suspected abuse does not result in serious bodily injury: An oral report by telephone shall be made to the local law enforcement agency within 24 hours after the suspected abuse

and a written report shall be made to the local law enforcement agency, the local ombudsperson and the corresponding licensing agency within 24 hours after the abuse; and

- If the suspected abuse is caused by a resident with a physician's diagnosis of dementia and there is no serious bodily injury, the reporter shall report to the local ombudsperson or law enforcement agency by telephone immediately or as soon as reasonably practicable and by written report within 24 hours.
- If the abuse occurred in a state mental hospital or a state developmental center and the alleged abuse or neglect resulted in death, sexual assault, an assault with a deadly weapon by a nonresident of a state mental hospital or a state developmental center, an assault with force likely to produce great bodily injury, an injury to the genitals where the cause is undetermined or a broken bone where the cause of the break is undetermined, then the report shall be made immediately (but in any event within 2 hours of the event) to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services and also to the local law enforcement agency.

What information must a report include?

Each county operates its own abuse reporting hotline.

The applicable telephone numbers can be found at: <http://www.cdss.ca.gov/Adult-Protective-Services/County-APS-Offices>

The written report shall be submitted on a form adopted by the State Department of Social Services (available at: <https://www.cdss.ca.gov/Portals/9/FMUForms/Q-T/SOC341.pdf>), which requires, among other things, the following:

- ✓ The name, e-mail address, telephone number, and occupation of the person reporting;
- ✓ The name, age, gender, sexual orientation, protected class, and address of the victim;
- ✓ The date, time, and place of the incident;
- ✓ Other details, including the reporter's observations and beliefs concerning the incident;
- ✓ Any statement relating to the incident made by the victim;
- ✓ The name of any individuals believed to have knowledge of the incident; and
- ✓ The name of the individuals believed to be responsible for the incident and their connection to the victim (suspected abuser).

Anything else I should know?

- ✓ A clergy member who acquires knowledge or reasonable suspicion of elder or dependent adult abuse during a penitential communication is not a mandated reporter.
- ✓ "Penitential communication" means a communication that is intended to be in confidence, including, but not limited to, a sacramental confession made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization, is authorized or accustomed to hear those communications and under the discipline tenets,

customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret.

- ✓ Nothing shall limit a clergy member's duty to report known or suspected elder and dependent adult abuse when he or she is acting in the capacity of a care custodian, health practitioner, or employee of an adult protective services agency.
- ✓ When two or more mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and when there is agreement among them, the telephone report or internet report may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist is not required to report an incident where all of the following conditions exist:

- ✓ The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect.
- ✓ The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- ✓ The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
- ✓ In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

In a long-term care facility, a mandated reporter is not required to report as a suspected incident of abuse, an incident where all of the following conditions exist:

- ✓ The mandated reporter is aware that there is a proper plan of care.
- ✓ The mandated reporter is aware that the plan of care was properly provided or executed.
- ✓ A physical, mental, or medical injury occurred as a result of care provided pursuant to the clauses above.
- ✓ The mandated reporter reasonably believes that the injury was not the result of abuse.

Any person who fails to make a required report, or impedes or inhibits a report, shall be guilty of a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than \$1,000, or both. Any mandated reporter who willfully fails to report, or impedes or inhibits a report, and the abuse results in death or great bodily injury shall be punished by not more than one year in a county jail, a fine of not more than \$5,000, or both.

Failure of a financial institution to report financial abuse shall be subject to a civil penalty not exceeding \$1,000 or if the failure to report is willful, a civil penalty not exceeding \$5,000, which

shall be paid by the financial institution that is the employer of the mandated reporter to the party bringing the action.

Any person who is not a mandated reporter under these laws who knows, or reasonably suspects, that an elder or a dependent adult has been the victim of abuse may report that abuse to a long-term care ombudsman program or local law enforcement agency, or both the long-term care ombudsman program and local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility.

Any person who is not a mandated reporter under these laws who knows, or reasonably suspects, that an elder or a dependent adult has been the victim of abuse in any place other than a long-term care facility may report the abuse to the county adult protective services agency or local law enforcement agency.

A mandated reporter of suspected financial abuse of an elder or dependent adult is authorized to not honor a power of attorney as to an attorney-in-fact, if the mandated reporter of suspected financial abuse of an elder or dependent adult makes a report to an adult protective services agency or a local law enforcement agency of any state that the principal may be subject to financial abuse, as described in this chapter or as defined in similar laws of another state, by that attorney-in-fact or person acting for or with that attorney-in-fact.

In any court proceeding or administrative hearing, neither the physician-patient privilege nor the psychotherapist-patient privilege applies to the specific information reported pursuant to this chapter.

Statutory citation(s):

Elder Abuse and Dependent Adult Civil Protection Act, Ca. Welf. & Inst. §§ 15600 et seq.

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

California law states that: “Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or local law enforcement agency is a mandated reporter.” (*Welfare and Institutions Code Section 15630, see Appendix 5*) A “care custodian” is defined as an administrator or an employee of a public or private facility who provides care for elders and dependent adults as part of his or her official duties, including support and maintenance staff. Therefore, all health practitioners and all employees in a long-term health care facility are mandated reporters.

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.

Reporting Exemptions

Under California law, there are certain designated health practitioners who are not required to report abuse or neglect when specific conditions exist. This exemption applies to only the following health practitioners:

- ➔ Physician and surgeon
- ➔ Registered nurse
- ➔ Psychotherapist

These certain individuals are not required to report an incident, where *all* of the following conditions exist:

- ➔ The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, or neglect.
- ➔ The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

This exemption only applies when an elder or dependent adult tells a psychotherapist that he or she has been the victim of physical or financial abuse; isolation; abduction; abandonment; or, neglect. It does not apply when the psychotherapist observes independently or has knowledge of an incident from other sources that reasonably appears to be physical or financial abuse; isolation; abduction; abandonment; or neglect.

Are BBS Trainees (MFT, LCSW, LPCC Trainees), Registered Associates Licensees Mandated Reporters of Elder and Dependent Adult Abuse?

BBS Trainees, associates, and licensees are mandated reporters of elder and dependent abuse in California. They are categorized as health practitioners, and health practitioners are mandated reporters of elder and dependent adult abuse when they are working within their professional capacities or the scope of their employment.

What Defines an Elder and Dependent Adult in California?

In the state of California, an elder is someone who lives/resides in California and is 65 years old or older. A dependent adult is:

- ◆ Between the ages of 18 and 64 and lives/resides in California and has physical or mental limitations that restrict his or her ability to carry out activities of daily living or protect his or her rights, or;
- ◆ Between the ages of 18 and 64 and is admitted as an inpatient into a twenty-four hour health facility.

California Codes on Mandated Reporting

WELFARE AND INSTITUTIONS CODES

Sections 15610 -15610.70

15610. The definitions contained in this article shall govern the construction of this chapter, unless the context requires otherwise.

15610.05. "Abandonment" means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

15610.06. "Abduction" means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court.

15610.07. (a) "Abuse of an elder or a dependent adult" means any of the following:

(1) Physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.

(2) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

(3) Financial abuse, as defined in Section 15610.30.

(b) This section shall become operative on July 1, 2016.

(Repealed (in Sec. 1) and added by Stats. 2015, Ch. 285, Sec. 2. (SB 196) Effective January 1, 2016. Section operative July 1, 2016, by its own provisions.)

15610.10. "Adult protective services" means those preventive and remedial activities performed on behalf of elders and dependent adults who are unable to protect their own interests, harmed or threatened with harm, caused physical or mental injury due to the action or inaction of another person or their own action as a result of ignorance, illiteracy, incompetence, mental limitation, substance abuse, or poor health, lacking in adequate food, shelter, or clothing, exploited of their income and resources, or deprived of entitlement due them.

15610.13. "Adult protective services agency" means a county welfare department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.

15610.15. "Bureau" means the Bureau of Medi-Cal Fraud within the office of the Attorney General.

15610.17. "Care custodian" means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff:

(a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(b) Clinics.

(c) Home health agencies.

(d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services.

(e) Adult day health care centers and adult day care.

(f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders.

(g) Independent living centers.

(h) Camps.

(i) Alzheimer's Disease day care resource centers.

(j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(k) Respite care facilities.

(l) Foster homes.

(m) Vocational rehabilitation facilities and work activity centers.

(n) Designated area agencies on aging.

(o) Regional centers for persons with developmental disabilities.

(p) State Department of Social Services and State Department of Health Services licensing divisions.

(q) County welfare departments.

(r) Offices of patients' rights advocates and clients' rights advocates, including attorneys.

(s) The office of the long-term care ombudsman.

(t) Offices of public conservators, public guardians, and court investigators.

(u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following:

(1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities.

(2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness.

(v) Humane societies and animal control agencies.

(w) Fire departments.

(x) Offices of environmental health and building code enforcement.

(y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.15610.19.

"Clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, synagogue, temple, mosque, or recognized religious denomination or organization.

"Clergy member" does not include unpaid volunteers whose principal occupation or vocation does not involve active or ordained ministry in a church, synagogue, temple, mosque, or recognized religious denomination or organization, and who periodically visit elder or dependent adults on behalf of that church, synagogue, temple, mosque, or recognized religious denomination or organization.

15610.20. "Clients' rights advocate" means the individual or individuals assigned by a regional center or state hospital developmental center to be responsible for clients' rights assurance for persons with developmental disabilities.

15610.23. (a) "Dependent adult" means any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age. (b) "Dependent adult" includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility, as defined in Sections **1250, 1250.2, and 1250.3** of the Health and Safety Code.

15610.25. "Developmentally disabled person" means a person with a developmental disability specified by or as described in subdivision (a) of Section 4512.

15610.27. "Elder" means any person residing in this state, 65 years of age or older.

15610.30. (a) "Financial abuse" of an elder or dependent adult occurs when a person or entity does any of the following:

(1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.

(2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.

(3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 1575 of the Civil Code.

(b) A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

(c) For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.

(d) For purposes of this section, "representative" means a person or entity that is either of the following:

- (1) A conservator, trustee, or other representative of the estate of an elder or dependent adult.
- (2) An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

15610.35. "Goods and services necessary to avoid physical harm or mental suffering" include, but are not limited to, all of the following:

- (a) The provision of medical care for physical and mental health needs.
- (b) Assistance in personal hygiene.
- (c) Adequate clothing.
- (d) Adequately heated and ventilated shelter.
- (e) Protection from health and safety hazards.
- (f) Protection from malnutrition, under those circumstances where the results include, but are not limited to, malnutrition and deprivation of necessities or physical punishment.
- (g) Transportation and assistance necessary to secure any of the needs set forth in subdivisions (a) to (f), inclusive.

15610.37. "Health practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, registered nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage and family therapist, licensed professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage and family therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, an unlicensed marriage and family therapist intern registered under Section 4980.44 of the Business and Professions Code, a clinical counselor trainee, as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code, a clinical counselor intern registered under Section 4999.42 of the Business and Professions Code, a state or county public health or social service employee who treats an elder or a dependent adult for any condition, a coroner, or a substance use disorder counselor. As used in this section, a "substance use disorder counselor" is a person providing counseling services in an alcoholism or drug abuse recovery and treatment program licensed, certified, or funded under Part 2 (commencing with Section 11760) of Division 10.5 of the Health and Safety Code.

15610.39. "Imminent danger" means a substantial probability that an elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his or her own action or inaction, or as a result of the action or inaction of another person.

15610.40. "Investigation" means that activity undertaken to determine the validity of a report of elder or dependent adult abuse.

15610.43. (a) "Isolation" means any of the following:

- (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.
- (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is

competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

(3) False imprisonment, as defined in Section 236 of the Penal Code.

(4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors.

(b) The acts set forth in subdivision (a) shall be subject to a rebuttable presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician and surgeon licensed to practice medicine in the state, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care. (c) The acts set forth in subdivision (a) shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

15610.45. "Local law enforcement agency" means a city police or county sheriff's department, or a county probation department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.

15610.47. "Long-term care facility" means any of the following:

(a) Any long-term health care facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code.

(b) Any community care facility, as defined in paragraphs (1) and (2) of subdivision (a) of Section 1502 of the Health and Safety Code, whether licensed or unlicensed.

(c) Any swing bed in an acute care facility, or any extended care facility.

(d) Any adult day health care facility as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code.

(e) Any residential care facility for the elderly as defined in Section 1569.2 of the Health and Safety Code.

15610.50. "Long-term care ombudsman" means the State Long-Term Care Ombudsman, local ombudsman coordinators, and other persons currently certified as ombudsmen by the Department of Aging as described in Chapter 11 (commencing with Section 9700) of Division 8.5.

15610.53. "Mental suffering" means fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts performed or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elder or dependent adult.

15610.55. (a) "Multidisciplinary personnel team" means any team of two or more persons who are trained in the prevention, identification, and treatment of abuse of elderly or dependent adults and who are qualified to provide a broad range of services related to abuse of elderly or dependent adults.

(b) A multidisciplinary personnel team may include, but is not limited to, all of the following:

(1) Psychiatrists, psychologists, or other trained counseling personnel.

(2) Police officers or other law enforcement agents.

(3) Medical personnel with sufficient training to provide health services.

(4) Social workers with experience or training in prevention of abuse of elderly or dependent adults.

(5) Public guardians.

(6) The local long-term care ombudsman.

(7) Child welfare services personnel.

15610.57. (a) "Neglect" means either of the following:

(1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(2) The negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition or dehydration.

(5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

15610.60. "Patients' rights advocate" means a person who has no direct or indirect clinical or administrative responsibility for the patient, and who is responsible for ensuring that laws, regulations, and policies on the rights of the patient are observed.

15610.63. "Physical abuse" means any of the following:

(a) Assault, as defined in Section 240 of the Penal Code.

(b) Battery, as defined in Section 242 of the Penal Code.

(c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.

(d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.

(e) Sexual assault, that means any of the following:

(1) Sexual battery, as defined in Section 243.4 of the Penal Code.

(2) Rape, as defined in Section 261 of the Penal Code.

(3) Rape in concert, as described in Section 264.1 of the Penal Code.

(4) Spousal rape, as defined in Section 262 of the Penal Code.

(5) Incest, as defined in Section 285 of the Penal Code.

(6) Sodomy, as defined in Section 286 of the Penal Code.

(7) Oral copulation, as defined in Section 288a of the Penal Code.

(8) Sexual penetration, as defined in Section 289 of the Penal Code.

(9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.

(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:

(1) For punishment.

(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.

(3) For any purpose not authorized by the physician and surgeon.

15610.65. "Reasonable suspicion" means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.

15610.67. "Serious bodily injury" means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.

15610.70. (a) "Undue influence" means excessive persuasion that causes another person to act or refrain from acting by overcoming that person's free will and results in inequity. In determining whether a result was produced by undue influence, all of the following shall be considered:

(1) The vulnerability of the victim. Evidence of vulnerability may include, but is not limited to, incapacity, illness, disability, injury, age, education, impaired cognitive function, emotional distress, isolation, or dependency, and whether the influencer knew or should have known of the alleged victim's vulnerability.

(2) The influencer's apparent authority. Evidence of apparent authority may include, but is not limited to, status as a fiduciary, family member, care provider, health care professional, legal professional, spiritual adviser, expert, or other qualification.

(3) The actions or tactics used by the influencer. Evidence of actions or tactics used may include, but is not limited to, all of the following:

(A) Controlling necessities of life, medication, the victim's interactions with others, access to information, or sleep.

(B) Use of affection, intimidation, or coercion.

(C) Initiation of changes in personal or property rights, use of haste or secrecy in effecting those changes, effecting changes at inappropriate times and places, and claims of expertise in effecting changes.

(4) The equity of the result. Evidence of the equity of the result may include, but is not limited to, the economic consequences to the victim, any divergence from the victim's prior intent or course of conduct or dealing, the relationship of the value conveyed to the value of any services or consideration received, or the appropriateness of the change in light of the length and nature of the relationship.

(b) Evidence of an inequitable result, without more, is not sufficient to prove undue influence.

WELFARE AND INSTITUTIONS CODE

Sections 15630-15633.5

15630. (a) Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a

local law enforcement agency, is a mandated reporter. (b) (1) Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63. abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool, as authorized by Section 15658, immediately or as soon as practicably possible. If reported by telephone, a written report shall be sent, or an Internet report shall be made through the confidential Internet reporting tool established in Section 15658, within two working days.

(A) If the suspected or alleged abuse is physical abuse, as defined in Section 15610.63, and the abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the following shall occur:

(i) If the suspected abuse results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately, but also no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(ii) If the suspected abuse does not result in serious bodily injury, a telephone report shall be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(iii) When the suspected abuse is allegedly caused by a resident with a physician's diagnosis of dementia, and there is no serious bodily injury, as reasonably determined by the mandated reporter, drawing upon his or her training or experience, the reporter shall report to the local ombudsman or law enforcement agency by telephone, immediately or as soon as practicably possible, and by written report, within 24 hours.

(iv) When applicable, reports made pursuant to clauses (i) and (ii) shall be deemed to satisfy the reporting requirements of the federal Elder Justice Act of 2009, as set out in Subtitle H of the federal Patient Protection and Affordable Care Act (Public Law 111-148), Section 1418.91 of the Health and Safety Code, and Section 72541 of Title 22 of California Code of Regulations. When a local law enforcement agency receives an initial report of suspected abuse in a long-term care facility pursuant to this subparagraph, the local law enforcement agency may coordinate efforts with the local ombudsman to provide the most immediate and appropriate response warranted to investigate the mandated report. The local ombudsman and local law enforcement agencies may collaborate to develop protocols to implement this subparagraph.

(B) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other law, the

department may implement subparagraph (A), in whole or in part, by means of all-county letters, provider bulletins, or other similar instructions without taking regulatory action.

(C) If the suspected or alleged abuse is abuse other than physical abuse, and the abuse occurred in a long-term care facility, except a state mental health hospital or a state developmental center, a telephone report and a written report shall be made to the local ombudsman or the local law enforcement agency.

(D) With regard to abuse reported pursuant to subparagraph (C), the local ombudsman and the local law enforcement agency shall, as soon as practicable, except in the case of an emergency or pursuant to a report required to be made pursuant to clause (v), in which case these actions shall be taken immediately, do all of the following:

(i) Report to the State Department of Public Health any case of known or suspected abuse occurring in a long-term health care facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code.

(ii) Report to the State Department of Social Services any case of known or suspected abuse occurring in a residential care facility for the elderly, as defined in Section 1569.2 of the Health and Safety Code, or in an adult day program, as defined in paragraph (2) of subdivision (a) of Section 1502 of the Health and Safety Code.

(iii) Report to the State Department of Public Health and the California Department of Aging any case of known or suspected abuse occurring in an adult day health care center, as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code.

(iv) Report to the Bureau of Medi-Cal Fraud and Elder Abuse any case of known or suspected criminal activity.

(v) Report all cases of known or suspected physical abuse and financial abuse to the local district attorney's office in the county where the abuse occurred.

(E) (i) If the suspected or alleged abuse or neglect occurred in a state mental hospital or a state developmental center, and the suspected or alleged abuse or neglect resulted in any of the following incidents, a report shall be made immediately, but no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting abuse, to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, and also to the local law enforcement agency:

(I) A death.

(II) A sexual assault, as defined in Section 15610.63.

(III) An assault with a deadly weapon, as described in Section 245 of the Penal Code, by a nonresident of the state mental hospital or state developmental center.

(IV) An assault with force likely to produce great bodily injury, as described in Section 245 of the Penal Code.

(V) An injury to the genitals when the cause of the injury is undetermined.

(VI) A broken bone when the cause of the break is undetermined.

(ii) All other reports of suspected or alleged abuse or neglect that occurred in a state mental hospital or a state developmental center shall be made immediately, but no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting abuse, to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, or to the local law enforcement agency.

(iii) When a local law enforcement agency receives an initial report of suspected or alleged abuse or neglect in a state mental hospital or a state developmental center pursuant to clause (i), the local law enforcement agency shall coordinate efforts with the designated investigators of the State Department of State Hospitals or the State Department of Developmental Services to provide the most immediate and appropriate response warranted to investigate the mandated report. The designated investigators of the State Department of State Hospitals or the State Department of Developmental Services and local law enforcement agencies may collaborate to develop protocols to implement this clause.

(iv) Except in an emergency, the local law enforcement agency shall, as soon as practicable, report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse.

(v) Notwithstanding any other law, a mandated reporter who is required to report pursuant to Section 4427.5 shall not be required to report under clause (i).

(F) If the abuse has occurred in any place other than a long-term care facility, a state mental hospital, or a state developmental center, the report shall be made to the adult protective services agency or the local law enforcement agency.

(2) (A) A mandated reporter who is a clergy member who acquires knowledge or reasonable suspicion of elder or dependent adult abuse during a penitential communication is not subject to paragraph (1). For purposes of this subdivision, "penitential communication" means a communication that is intended to be in confidence, including, but not limited to, a sacramental confession made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization is authorized or accustomed to hear those communications and under the discipline tenets, customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret.

(B) This subdivision shall not be construed to modify or limit a clergy member's duty to report known or suspected elder and dependent adult abuse if he or she is acting in the capacity of a care custodian, health practitioner, or employee of an adult protective services agency.

(C) Notwithstanding any other provision in this section, a clergy member who is not regularly employed on either a full-time or part-time basis in a long-term care facility or does not have care or custody of an elder or dependent adult shall not be responsible for reporting abuse or neglect that is not reasonably observable or discernible to a reasonably prudent person having no specialized training or experience in elder or dependent care.

(3) (A) A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report, pursuant to paragraph (1), an incident if all of the following conditions exist:

(i) The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect.

(ii) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

(iii) The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.

(iv) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the

psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

(B) This paragraph shall not be construed to impose upon mandated reporters a duty to investigate a known or suspected incident of abuse and shall not be construed to lessen or restrict any existing duty of mandated reporters.

(4) (A) In a long-term care facility, a mandated reporter shall not be required to report as a suspected incident of abuse, as defined in Section 15610.07, an incident if all of the following conditions exist:

(i) The mandated reporter is aware that there is a proper plan of care.

(ii) The mandated reporter is aware that the plan of care was properly provided or executed.

(iii) A physical, mental, or medical injury occurred as a result of care provided pursuant to clause (i) or (ii).

(iv) The mandated reporter reasonably believes that the injury was not the result of abuse.

(B) This paragraph shall not be construed to require a mandated reporter to seek, nor to preclude a mandated reporter from seeking, information regarding a known or suspected incident of abuse prior to reporting. This paragraph shall apply only to those categories of mandated reporters that the State Department of Public Health determines, upon approval by the Bureau of Medi-Cal Fraud and Elder Abuse and the state long-term care ombudsman, have access to plans of care and have the training and experience necessary to determine whether the conditions specified in this section have been met.

(c) (1) Any mandated reporter who has knowledge, or reasonably suspects, that types of elder or dependent adult abuse for which reports are not mandated have been inflicted upon an elder or dependent adult, or that his or her emotional well-being is endangered in any other way, may report the known or suspected instance of abuse.

(2) If the suspected or alleged abuse occurred in a long-term care facility other than a state mental health hospital or a state developmental center, the report may be made to the long-term care ombudsman program. Except in an emergency, the local ombudsman shall report any case of known or suspected abuse to the State Department of Public Health and any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

(3) If the suspected or alleged abuse occurred in a state mental health hospital or a state developmental center, the report may be made to the designated investigator of the State Department of State Hospitals or the State Department of Developmental Services or to a local law enforcement agency. Except in an emergency, the local law enforcement agency shall report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse, as soon as is practicable.

(4) If the suspected or alleged abuse occurred in a place other than a place described in paragraph (2) or (3), the report may be made to the county adult protective services agency.

(5) If the conduct involves criminal activity not covered in subdivision (b), it may be immediately reported to the appropriate law enforcement agency.

(d) If two or more mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and there is agreement among them, the telephone report or Internet

report, as authorized by Section 15658, may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(e) A telephone report or Internet report, as authorized by Section 15658, of a known or suspected instance of elder or dependent adult abuse shall include, if known, the name of the person making the report, the name and age of the elder or dependent adult, the present location of the elder or dependent adult, the names and addresses of family members or any other adult responsible for the elder's or dependent adult's care, the nature and extent of the elder's or dependent adult's condition, the date of the incident, and any other information, including information that led that person to suspect elder or dependent adult abuse, as requested by the agency receiving the report.

(f) The reporting duties under this section are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with this chapter.

(g) (1) Whenever this section requires a county adult protective services agency to report to a law enforcement agency, the law enforcement agency shall, immediately upon request, provide a copy of its investigative report concerning the reported matter to that county adult protective services agency.

(2) Whenever this section requires a law enforcement agency to report to a county adult protective services agency, the county adult protective services agency shall, immediately upon request, provide to that law enforcement agency a copy of its investigative report concerning the reported matter.

(3) The requirement to disclose investigative reports pursuant to this subdivision shall not include the disclosure of social services records or case files that are confidential, nor shall this subdivision be construed to allow disclosure of any reports or records if the disclosure would be prohibited by any other provision of state or federal law.

(h) Failure to report, or impeding or inhibiting a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars (\$1,000), or by both that fine and imprisonment. Any mandated reporter who willfully fails to report, or impedes or inhibits a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, if that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars (\$5,000), or by both that fine and imprisonment. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency specified in paragraph (1) of subdivision (b) of Section 15630 discovers the offense. (i) For purposes of this section, "dependent adult" shall have the same meaning as in Section 15610.23.

15633. (a) The reports made pursuant to Sections 15630, 15630.1, and 15631 shall be confidential and may be disclosed only as provided in subdivision (b). Any violation of the confidentiality required by this chapter is a misdemeanor punishable by not more than six months in the county jail, by a fine of five hundred dollars (\$500), or by both that fine and imprisonment. (b) Reports of suspected abuse of an elder or dependent adult and information contained therein may be disclosed only to the following:

(1) Persons or agencies to whom disclosure of information or the identity of the reporting party is permitted under Section 15633.5.

(2) (A) Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention, identification, or treatment of abuse of elderly or dependent persons. (B) Except as provided in subparagraph (A), any personnel of the multidisciplinary team or agency that receives information pursuant to this chapter, shall be under the same obligations and subject to the same confidentiality penalties as the person disclosing or providing that information. The information obtained shall be maintained in a manner that ensures the maximum protection of privacy and confidentiality rights. (c) This section shall not be construed to allow disclosure of any reports or records relevant to the reports of abuse of an elder or dependent adult if the disclosure would be prohibited by any other provisions of state or federal law applicable to the reports or records relevant to the reports of the abuse, nor shall it be construed to prohibit the disclosure by a financial institution of any reports or records relevant to the reports of abuse of an elder or dependent adult if the disclosure would be required of a financial institution by otherwise applicable state or federal law or court order.

15633.5. (a) Information relevant to the incident of elder or dependent adult abuse may be given to an investigator from an adult protective services agency, a local law enforcement agency, the office of the district attorney, the office of the public guardian, the probate court, the bureau, or an investigator of the Department of Consumer Affairs, Division of Investigation who is investigating a known or suspected case of elder or dependent adult abuse.

(b) The identity of any person who reports under this chapter shall be confidential and disclosed only among the following agencies or persons representing an agency:

(1) An adult protective services agency.

(2) A long-term care ombudsperson program.

(3) A licensing agency.

(4) A local law enforcement agency.

(5) The office of the district attorney.

(6) The office of the public guardian.

(7) The probate court.

(8) The bureau.

(9) The Department of Consumer Affairs, Division of Investigation.

(10) Counsel representing an adult protective services agency.

(c) The identity of a person who reports under this chapter may also be disclosed under the following circumstances:

(1) To the district attorney in a criminal prosecution.

(2) When a person reporting waives confidentiality.

(3) By court order.

(d) Notwithstanding subdivisions (a), (b), and (c), any person reporting pursuant to Section 15631 shall not be required to include his or her name in the report.

PENAL CODE Section 368

(a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b) (1) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars (\$6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

(2) If, in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:

(A) Three years if the victim is under 70 years of age.

(B) Five years if the victim is 70 years of age or older.

(3) If, in the commission of an offense described in paragraph (1), the defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:

(A) Five years if the victim is under 70 years of age.

(B) Seven years if the victim is 70 years of age or older.

(c) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars (\$2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is

punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars (\$2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars (\$10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars (\$950).

(2) By a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars (\$950).

(e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars (\$2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars (\$10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars (\$950).

(2) By a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars (\$950).

(f) Any person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

(g) As used in this section, "elder" means any person who is 65 years of age or older.

(h) As used in this section, "dependent adult" means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(i) As used in this section, "caretaker" means any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult.

(j) Nothing in this section shall preclude prosecution under both this section and Section 187 or 12022.7 or any other provision of law. However, a person shall not receive an additional term of imprisonment under both paragraphs (2) and (3) of subdivision (b) for any single offense, nor shall a person receive an additional term of imprisonment under both Section 12022.7 and paragraph (2) or (3) of subdivision (b) for any single offense.

(k) In any case in which a person is convicted of violating these provisions, the court may require him or her to receive appropriate counseling as a condition of probation. Any defendant ordered to be placed in a counseling program shall be responsible for paying the expense of his or her participation in the counseling program as determined by the court. The court shall take into consideration the ability of the defendant to pay, and no defendant shall be denied probation because of his or her inability to pay.

(l) Upon conviction for a violation of subdivision (b), (c), (d), (e), or (f), the sentencing court shall also consider issuing an order restraining the defendant from any contact with the victim, which may be valid for up to 10 years, as determined by the court. It is the intent of the Legislature that the length of any restraining order be based upon the seriousness of the facts before the court, the probability of future violations, and the safety of the victim and his or her immediate family. This protective order may be issued by the court whether the defendant is sentenced to state prison or county jail, or if imposition of sentence is suspended and the defendant is placed on probation. <http://leginfo.legislature.ca.gov/>

Where and How to Report in California

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. To report abuse, call this number 1-833-401-0832 and when prompted enter your 5-digit zip code to be connected to the Adult Protective Services in your county, 7 days a week, 24 hours a day. If you want to report elder abuse or dependent adult abuse in the community, contact your local county APS Office. Abuse reports may also be made to your local law enforcement agency. **For free online California mandated reporter training, please visit <https://cdss.ca.gov/MandatedReporting/story.html>**

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.

California Codes on Mandated Reporting https://cdss.ca.gov/MandatedReporting/story_content/external_files/California%20Codes%20for%20Mandated%20Reporters.pdf

Please find the CA form “REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE” here https://cdss.ca.gov/MandatedReporting/story_content/external_files/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>

FOR USE BY FINANCIAL INSTITUTIONS REPORT OF SUSPECTED DEPENDENT ADULT/ELDER FINANCIAL ABUSE https://cdss.ca.gov/MandatedReporting/story_content/external_files/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)

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. Screening, Assessment, and Intervention Tools

The World Health Organization (WHO) Cancer Program website defines screening as the “presumptive identification of unrecognized disease or defects by means of tests, examinations, or other procedures that can be applied rapidly”. It also claims that “the success of screening depends on having sufficient numbers of personnel to perform the screening tests and on the availability of facilities that can undertake subsequent diagnosis, treatment, and follow-up”.

The United States Preventive Services Task Force defines screening for violence as: “Assessment of current harm or risk of harm from family and intimate partner violence in asymptomatic persons in a health care setting. Individuals presenting with injuries from family violence undergo a diagnostic, not screening, evaluation. Universal screening means assessing everyone; selective screening indicates that only those who meet specific criteria are assessed. It is important to distinguish between screening, directed at the entire population potentially at risk, whereby individuals are put into an “elevated probability” group for further evaluation, and case finding, or diagnostic evaluation whereby an actual designation of elder abuse is made based on indicators raising the suspicion of abuse. In both research and practice, the two approaches encompass different levels of rigor and investigation.

Benefit vs. Harm

Potential Benefits and Potential Harms of Screening

Potential Benefits

- ✓ Screening is critical for early detection and prevention of elder abuse (Burnett et al.).
- ✓ 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).
- ✓ An encounter with a professional may be an elder’s only chance to change an abusive situation and prevent its continuation or exacerbation (Cohen).

- ✓ Early detection and interventions as a result of screening may help ameliorate or stop elder abuse (Dong).

Potential Harms

Screening poses an additional challenge for APS agencies, which are already overwhelmed and under-resourced (O'Brien in Dong).

- ➔ 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).
- ➔ Initiatives to promote awareness of elder abuse are encouraging, but fail to meet threshold to justify screening (O'Brien in Dong).
- ➔ Existing tools are problematic because they don't detect common forms of abuse including financial and neglect (O'Brien in Dong).

The basic principle of screening tools and programs is that they “do more good than harm”.

Among the criteria used by most countries to assess a screening program are the following:

- ➔ The condition should be an important health problem, well understood and with a known risk factor, or indicator.
- ➔ The test should be simple, safe and validated
- ➔ The screening test should be acceptable to the population.
- ➔ There should be available effective interventions to follow up.
- ➔ There must be evidence from reliable randomized controlled trials that the screening program reduces mortality or morbidity and is cost effective.
- ➔ There are adequate staff available.
- ➔ There should be evidence that the complete screening program (from test to intervention) is “clinically, socially and ethically acceptable to health professionals and the public”.

The choice in the order of the words – “clinically” first “socially” second and “ethical” third – reflects again the supremacy of the clinical medical model.

Screening has been described as “a double edged sword, sometimes used clumsily by the well-intended” as the value of screening for diseases such as cancer and others is also debated.

The United States Preventive Services Task Force makes clear that it evaluates the balance of benefits and harms based exclusively on the quality and magnitude of the evidence. The literature review that led to the Task Force's recommendation did not find any studies that provide data on possible adverse effects of screening or interventions. The Task Force claims that false-negative tests may discourage clinicians from seeking further history and prevent identification of those individuals who are truly at risk. False-positive tests, on the other hand, can lead to labelling and punitive attitudes as well as psychological distress, and might lead to family tension, loss of personal residence and financial resources and loss of autonomy for the victim.

The main approach to detection of elder abuse has been through identifying high-risk factors.

Research published in the past decade has repeatedly described several risk factors that appear to increase the likelihood of abuse. The complexity of the task related to risk assessment emphasizes the crucial role of the doctor's judgement in identifying abuse. Two surveys of general practitioners conducted by McCreadie et al. in London and Birmingham, England, revealed that less than half the general practitioners had identified a case of elder abuse in the previous year. These studies seem to indicate that general practitioners' personal knowledge of at least five risk factors paired with a long-term doctor-patient relationship, especially through home visiting, facilitates diagnosis of abuse.

The main risk factors for elder abuse are generally considered to be:

- ➡ Social isolation of the abused person and/or the family;
- ➡ Frailty of the victim, functional disability and cognitive impairment;
- ➡ Pathology of the abuser, such as alcohol or other substance abuse, cognitive impairment and mental-health problems;
- ➡ Caregiver stress or anger
- ➡ Dependence of the victim on the abuser (e.g. the caregiver is the abuser) or dependence of the abuser on the victim (e.g. an adult child with financial dependence on the parent is the abuser).

The risk factors listed above are as critiqued earlier, gender-neutral and do not consider the possibility of non-dependent older persons being abused. Findings of the one study to date on the incidence of abuse among postmenopausal women suggest that there is a transition in the risk factors for abuse of women as they age. As long as the woman remains independent, risk factors are like those for domestic violence; if she becomes dependent, then the risk factors become those of caregiver abuse and neglect. Since older persons may present signs and symptoms of a multiplicity of factors due to aging, such as frail skin, or a fall, or confusion, it is very important to always think broadly in each circumstance and to be alert in order to provide for the safety of the patient and optimal care and to avoid false accusations. Functional impairment, in addition to being a risk factor in itself, may diminish greatly the capacity of older people to defend themselves. An increased awareness of the psychosocial reality of the patient will assist in understanding the contextual factors that may be strong predictors of 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. 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.

Key Recommendations for Practice

<u>CLINICAL RECOMMENDATION</u>	<u>COMMENTS</u>
Routinely inquire and assess risk of and suspected elder abuse.	The Elder Abuse Suspicion Index can be used to assess for risk factors for elder abuse.
Screening for cognitive impairment should be performed before screening for abuse in older persons.	Providers should be aware of medical conditions and medication effects that can mimic abuse in older persons.
Disease-oriented evidence- Patients and should be interviewed separately when screening for elder abuse.	Specific patterns of injury are more caregivers suspicious for intentional injury in older persons.

Elder Abuse Screening Tools

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.

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)

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. Additionally, three validated instruments have been developed by Reis & Nahmiash:

The Brief Abuse Screen for the Elderly (BASE)

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?

within 24 hours immediately 24-72 hours 1 week 2 or more weeks

The Caregiver Abuse Screen (CASE) consists of eight questions to caregivers. It is used to detect abuse in cognitively impaired adults. It does not address the patient directly. Although this tool may facilitate the difficult task of interviewing a suspected abuser, it assumes only the caregiver model and ignores the autonomy of the patient.

The Indicators of Abuse Screen (IOA) is a 48-point checklist of problem indicators for abuse that is completed by health care professionals in the context of a comprehensive home assessment. The tool addresses the patient directly. The tool builds on the professional's assessment skills. For example, some of the items to be checked by the professional are whether the patient has behavioral problems, alcohol or medication problems or poor current relationships. This is clearly not a screening tool for the clinical setting, but it has been recognized as a potentially good research instrument.

The Elder Assessment Instrument (EAI) includes a general assessment of the older person as well as specific physical, social and medical assessments and level of independence in lifestyle. It has been used by elder abuse teams and nurses in the emergency departments.

The Elder Abuse Suspicion Index (EASI) was developed with the goal of establishing a reasonable level of suspicion in order to justify referral to an appropriate community service (such as a social worker) for in-depth assessment. The theory behind this is that a simple tool can grant the patient permission to talk and can generate a level of suspicion and not necessarily a diagnosis. It is aimed at general practitioners, general internists and geriatricians with the intention to expand and test it also with social workers and nurses. It is a short five-question tool directed at the older person, with one observation item to be completed by the doctor.

Through the tools described, the difference of approaches towards screening and assessment, and the underlying theories, are noticeable. Only two tools (H-S/EAST and EASI) target the older person with direct questions. The heavy influence of the caregiver model in the design of the other tools is evident.

The Life Events Checklist

(Source: The National Center for PTSD)

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

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.

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

Interview Client and Caregiver Separately

An older patient's neurologic, cognitive, or psychiatric conditions and family dynamics may create barriers to obtaining a reliable history. Communicating with older persons may also require more patience and understanding of the possible generational and cultural barriers for bringing up a taboo issue. Fear of retaliation, shame, dependency on the caregiver, and lack of privacy may hinder disclosure. 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 crucial concern when communicating with a frail older person, regardless of whether that person is suffering from cognitive impairment or not, is to make sure that the caregiver does not dominate the conversation, by holding separate interviews with both the patient and the caregiver. 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.

Trust

Five dimensions can be identified in practitioner behavior that are essential for the building of trust with their patients and that contribute to disclosure:

- ✓ Open communication
- ✓ Professional competency
- ✓ A friendly practice style
- ✓ A caring attitude
- ✓ Emotional equality

A victim of abuse can experience dramatic relief when a provider verbally recognizes an emotional state the patient is in or helps the patient express an emotion. These emotions can often be recognized from clues in the patient's or abuser's behavior, these clues sometimes being like "cries for help".

Confidentiality is an important concept that is much present in the literature as a major

barrier for identification and/or disclosure of abuse and impacting the relationship of trust. The concept is often used indiscriminately while it refers to different situations. This creates confusion as to what is really meant by it, and when and how confidentiality rules need to be followed.

Communication between different care professionals

The barriers that prevent a trusting relationship between a provider and a patient parallel the barriers that prevent good work across disciplines. However, it also provides an opportunity to develop good practice on elder abuse and violence through sound inter-professional partnerships.

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.). Recent research suggests that only 1.4% of cases reported to Adult Protective Services come from physicians

Management and Intervention

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, and stored in a safe place. A safety plan may include:

- Safe places to go, such as the home of a friend or family member, a shelter, or the hospital
- A checklist of essential items to keep together in a safe place
- Telephone numbers of family, friends, community organizations, and emergency service providers
- Special considerations, such as transportation needs, if the client 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).

<u>RESOURCE</u>	<u>DESCRIPTION</u>
Administration on Aging	Elder abuse tools and resources with information on how to protect older persons
American Medical Association	Policy regarding family and intimate partner violence
Eldercare Locator	Resource for finding local resources by zip code or community
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
University of Maine Center on Aging	Steps to develop a safety plan for older persons (from Maine Partners for Elder Protection pilot project)

5. Intimate Partner And Domestic Violence Later In Life

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 IPV 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.

IPV later in 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. 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. IPV 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

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.

Intimate Partner and 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.

IPV 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.

IPV 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.

6. Elder Abuse in the Age of Covid-19

Elder Abuse in the Time of COVID-19—Increased Risks for Older Adults and Their Caregivers
Lena K. Makaroun, M.D., M.S., Rachel L. Bachrach, Ph.D., Ann-Marie Rosland, M.D., M.S.

Since the first case of the novel coronavirus SARSCoV-2 causing the COVID-19 illness was diagnosed in the United States on January 20, 2020, a steady stream of new policy measures have been enacted to protect the public from this growing pandemic. At the forefront of these efforts have been measures to limit interpersonal contact to prevent transmission of the virus. Social distancing, school closures, and the shuttering of nonessential businesses have already led to significant personal, social, and economic hardship. While it has been well publicized that older adults are at highest risk of serious illness and death from COVID-19, they may also be at high risk for negative consequences from the measures being enacted to protect them from the viral threat. Healthcare providers should be aware that their older patients are now particularly vulnerable to social isolation, financial hardship, difficulties accessing needed care and supplies, and anxiety about avoiding COVID-19; the family caregivers these patients often rely on are also vulnerable to increased stress from financial hardships and competing demands on their time. Unfortunately, all of these factors are known to be associated with increased risk of elder abuse for older adults.

Elder abuse often results from a combination of factors related to the older adult themselves, caregivers and others in the adult's social circle, and the context in which they all live and co-exist. The public policy measures being enacted for COVID-19, and their downstream mental health consequences, are likely having impacts on each of these areas in ways that increase the likelihood of older adults experiencing abuse.

COVID-19 IMPACTS ON OLDER ADULTS

For older adults themselves, social isolation is a known risk factor for experiencing elder abuse. The social distancing measures enacted to combat SARSCoV-2 transmission, and recommendations by the Centers for Disease Control and Prevention for adults over the age of 65 to not leave their homes, are undoubtedly creating new degrees of social isolation even among those previously well connected. These limits on in-person contact can greatly limit ability for caregivers to provide care in person, and in general limit opportunities for ongoing elder abuse to be detected by others. In addition, with unprecedented drops in the stock market, older adults may see any investments or retirement savings plummet, leading to financial instability, which is

known to make them more vulnerable to financial scams and other types of abuse. Older adults, who often have chronic health conditions, may now find it more difficult to access healthcare and supplies needed to manage their conditions and stay healthy. All of these issues— isolation, financial stress, and concerns about health—can in turn lead to increased depression and anxiety, which is also known to make older adults more susceptible to suffering abuse. While many older adults previously turned to their healthcare providers for treatment of these mental health symptoms, cancellations of face-to-face visits and unfamiliarity with technologies needed to conduct remote healthcare visits may be preventing older adults from receiving the care they need.

COVID-19 IMPACTS ON CAREGIVERS

Caregivers of older adults, who ordinarily deal with stress and systemic lack of support in the United States, are now facing even more burdens which are known to increase caregivers' risk of being abusive to or neglectful of their older care recipients. Caregivers of older adults are frequently family and friends of working age who, in 2013, collectively sacrificed \$67 billion in lost wages as a result of unpaid caregiving for their loved ones. With over 20 million people filing for unemployment in the United States from mid-March to mid-April 2020, and this number expected to grow, many caregivers are undoubtedly facing new financial strains. Low financial means and financial co-dependency with the care recipient are likely on the rise and are known risk factors for caregiver abuse of older adults. In addition, many caregivers are experiencing increased demands on their time, including increased time caring for children home from closed schools, for other family members who have fallen ill, or increased time working outside the home for those in key service sector jobs. These increased financial stressors, time demands, and worries about their care recipient's health may be contributing to the large increase in adults' anxiety about loved ones observed in a recent study. In response to increased anxiety, caregivers already struggling with unhealthy use of alcohol or other drugs may increase their use, and caregivers who are in remission from a substance use disorder may experience relapse. Decreased availability of in-person treatment or support programs, and limited ability to use other healthier coping strategies like exercise, may exacerbate these issues. Unfortunately, substance use disorder is also known to add to caregivers' risk of using abusive behavior.

COVID-19 IMPACTS ON THE CAREGIVING CONTEXT

Contextual factors in which caregiver-care recipient dyads function are also rapidly changing. In addition to competing demands on caregivers' time, many may simply be afraid to spend time in physical contact with an older adult due to concern for contagion. This can inadvertently lead to neglect of older adults. With more limited ability to have in-person contact, many caregivers are trying to use virtual technologies to stay connected with their care recipient. While some older adults may be comfortable with these technologies, many are not, and those with limited financial means may not have the necessary smart phone, computer or high-speed internet to use them. Furthermore, while certain care tasks might be readily replaced by virtual interaction (e.g., medication reminders), many more require in-person contact and may not be carried out during this time, leading to neglect of care that can have significant personal and health consequences. In addition to increased risks for new abusive situations arising, this pandemic may be worsening the severity or lethality of existing abusive relationships. For example, with increases in social distancing, not only was there a rush to buy food and other household products, but there was a substantial increase in the purchase of firearms and ammunition. If mood disorders and substance

use increase, both on the part of older adults and their caregivers, having easy access to lethal means at home may significantly increase the ability of violence to become deadly. With social distancing requiring a higher bar for in-person evaluations not only from healthcare and crisis professionals, but also from police and Adult Protective Services, these violent situations in the home may be less likely to be identified and intervened upon.

CONFRONTING INCREASED ELDER ABUSE RISK DURING THE COVID-19 PANDEMIC

So, what can we as providers do? In the face of the many challenges presented by the current COVID-19 crisis, there are also many opportunities. First, as healthcare providers doing telephonic or video visits with our older adult patients, we have a unique chance to observe our patients in their home environment. This is a rare window into how they are living, caring for themselves and being cared for by others. We can systematically observe for signs of unsafe situations, and directly inquire about older adults' safety and well-being. For example, we can ask about food insecurity. Second, these visits present opportunities for us to provide support for caregivers, many of whom may not typically attend clinic visits. Caregivers may live with patients, and often help patients connect to phone or video remote visits, especially for the most vulnerable older adult patients (e.g., those with dementia). Caregivers who live apart from patients may find it easier to call into remote visits than they did participating in in-person clinic visits. Caregivers may be more comfortable disclosing sensitive information related to their ability to provide care when speaking from a home environment. Healthcare providers can assess caregiver stress, ability to maintain previous levels of caregiving, and ability to access necessary resources and supplies. Providers can then provide brief counseling, problem-solving strategies, and appropriate referrals. Digital technologies and remote visits also present challenges. For older adults without the financial means or tech savvy, video tele-visits may be unfeasible. Proactive assessment and cataloging of patients' access to the necessary devices and internet or data services to identify those with limitations can allow for alternative strategies with these patients, such as simple telephone visits, or—if having an urgent medical concern—considering the risks and benefits of in-person evaluation, either in clinic or via in-home assessment. An additional challenge related to detecting elder abuse is the inability to know reliably when you are evaluating a patient via a virtual-visit if the patient is really alone. While caregiver presence can have benefits as previously discussed, it may also hinder disclosure of abuse or neglect if present. One potential strategy to approaching patients where elder abuse is a concern may be to make an unscheduled call to the older adult, so the caregiver cannot plan ahead to be present. On our side is an unprecedented and rapid mobilization of resources available in our healthcare systems and communities to support older adults and caregivers in need. For example, the Veterans Health Administration (VA) has information regarding coping with stress and related resources for those individuals concerned about their mental health and well-being during the COVID-19 pandemic. The VA is also providing free peer support services via twice weekly phone meetings for any Veteran wanting to talk and receive support from certified Peer Specialists during this pandemic. Outside the VA, Kaiser Permanente has launched an innovative “Food for Life” program to contact more than 450,000 members in California to identify those struggling to pay for food and provide application support to help them apply for food benefits. Local Area Agencies on Aging are another resource for all health systems, providing a range of services to meet the social needs of older adults, including home-delivered meals, personal care services, health promotion and chronic disease management, transportation, and social engagement. Recent research has shown that older patients benefit when their health systems

partner with Area Agencies on Aging, and the new challenges presented by the COVID-19 pandemic present an important opportunity to forge these new partnerships. If we suspect emerging mental health or substance use needs for either the older adult or caregiver, and referrals to local resources are scarce, several national agencies (e.g., the US Substance Abuse and Mental Health Services Administration) have dedicated COVID-19 webpages that list resources for patients as well as providers. Some of these resources include links to virtual recovery groups (e.g., Alcoholics Anonymous) for those patients interested in receiving support from peers. Familiarizing ourselves with these websites and resources will be important for our patients in the coming weeks and months. In our communities, we are seeing an outpouring of support from individuals and organizations reaching out to their older neighbors in caring ways. Encouraging our older patients to forge new bonds being made possible during this pandemic will be more important than ever. We can facilitate older patients connect to neighboring families who can help check on their well-being, to volunteers who can pick up needed groceries,²¹ and to local organizations that will donate supplies to community older adults, which can help fill in gaps, decrease isolation, and reduce unmet needs. This pandemic also presents an opportunity for research expanding our understanding of elder abuse. Perhaps most understudied, and the area where new revelations could have the biggest impact, are caregiver-related risk factors. With many people experiencing caregiving stress and concern about whether loved ones' needs will be met, caregivers may be more open to participating in research to share their experiences, even uncomfortable ones. Surveys of caregivers of older adults being conducted now in the context of COVID could include questions related to risks of using abusive or neglectful behavior. Other geriatrics and caregiving researchers should be mindful about the potential increased risk of elder abuse during this time, and could consider incorporating assessments related to this area in their studies. Being aware of the challenges older adults and their caregivers are facing is critical to helping them survive and thrive during this crisis. Attending to mental health needs, addressing increased risks, and connecting older adults to financial and caregiving resources may all help our patients and their loved ones be safer and avoid abusive and violent situations. We must not let out-of-sight mean out-of-mind—our older patients need us now, more than ever.

7. The Elder Justice Roadmap

Elder abuse including physical, sexual, and psychological abuse, as well as neglect, abandonment, and financial exploitation causes 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:
 1. First Wave Action Items – Priorities to address first, chosen by subject matter experts based on criteria outlined in this document
 2. 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.
 3. Universal Themes that Cut across Domains – Vital issues that arose repeatedly.

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, Latino, poor, and isolated older adults are disproportionately victimized.
- * For every 1 case of elder abuse that comes to light, another 23 remain hidden.

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

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. 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

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

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

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. 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.

8. 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
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)
California Association of Area Agencies on Aging (C4A)
California Caregiver Resource Centers
California District Attorneys Association
California Foundation of Independent Living Centers
Child and Family Policy Institute of California
County Welfare Directors Association of California

Additional Resources

California Department of Social Services – Adult Protective Services

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.

California Long-Term Care Ombudsman Association

The California Long-Term Care Ombudsman Association (CLTCOA) is dedicated to improving the accessibility and quality of long-term care ombudsman services for elders and vulnerable adults living in nursing homes, residential care facilities and other long-term care facilities across California.

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

Eldercare Locator

A public service of the Administration on Aging with the U.S. Administration for Community Living, Eldercare Locator is a nationwide service that connects older Americans and their caregivers with trustworthy local support resources. Since 1991, the Eldercare Locator has been linking those who need assistance with state and local agencies on aging, as well as community-based organizations that serve older adults and their caregivers. 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.

Know Fraud

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

National Association of Adult Protective Services Administrators

National Center on Elder Abuse
Elder Abuse Awareness Kit
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)

Established by with Administration on Aging with the U.S. Administration for Community Living, the National Center on Elder Abuse provides the latest information regarding research, training, best practices, news and resources on elder abuse, neglect and exploitation to professionals and the public.
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 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

National Indian Council on Aging, Inc. (NICA)

10501 Montgomery Boulevard, NE Suite 210
Albuquerque, NM 87111
1-505-292-2001

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>

U.S. Department of Justice – Elder Justice Initiative

The mission of the Elder Justice Initiative is to support and coordinate the Department of Justice's enforcement and programmatic efforts to combat elder abuse, neglect and financial fraud scams that target our nation's seniors.

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:

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.ama-assn.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/>

9. Bibliography

Abramson, B., Brandl, B., Meuer, T., & Raymond, J. (2007). Isolation as a Domestic Violence Tactic in Later Life Cases: What Attorneys Need to Know. *NAELA Journal*, III(1), 47-66.

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and Correlates of Emotional, Physical, Sexual, and

Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, 100(2), 292-297.

American Bar Association Commission on Law and Aging. (2013). *Guardianship Law & Practice*. Retrieved from http://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice.html.

American Bar Association Commission on Law and Aging. (2011). *Handbooks on Volunteer Guardianship Monitoring and Assistance: Serving the Court and Community*. Retrieved from http://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/court_volunteer_guardianshipmonitoring.html.

American Probation and Parole Association (Producer). (2006). *Elder Abuse Awareness. Community Corrections Role as the Eyes and Ears of the Community* [CD-ROM]. Available from http://www.appanet.org/eweb/dynamicpage.aspx?webcode=GeneralPosting&wps_key=4bb19011-1edb-40b5-9500-fbb266846f1c.

Anetzberger, G. J. (2012). An Update on the Nature and Scope of Elder Abuse. *Generations*, 36(3), 12- 20. The Elder Justice Roadmap—Appendices 54

Anetzberger, G. J., Dayton, C., Miller, C. A., McGreevey, J. F., & Schimer, M. (2005). Multidisciplinary teams in the clinical management of elder abuse. *Clinical Gerontologist*, 28(1/2), 157-171.

Anetzberger, G. J., Palmisano, B. R., Sanders, M., Bass, D. Dayton, C., Eckert, S., & Schimer, M. R. (2000). A model intervention for elder abuse and dementia. *The Gerontologist*, 40(4), 492-497.

Aravanis, S. C., Adelman, R. D., Breckman, R., Fulmer, T. T., Holder, E., Lachs, M. S., O'Brien, J. G., & Sanders, A. B. Diagnostic and treatment guidelines on elder abuse and neglect. *Archives of Family Medicine*, 2(4), 371-388.

Aravanis, S., & Downs, C. (2002). *Sentinels: Reaching Hidden Victims - Project Final Report*. Washington, DC: National Center on Elder Abuse.

Assunção, L., Grams, A. C., Ribeiro, C. S., & Magalhães, T. (2011). “Broken Heart” Syndrome in an Elder Abuse Case: Forensic Considerations from the Case. *Forensic Science, Medicine and Pathology*, 7(2), 217-221.

Baker, M. W., & Heitkemper, M. M. (2005). The roles of nurses on interprofessional teams to combat elder mistreatment. *Nursing Outlook*, 53(5), 253-259.

Baker, M. W., LaCroix, A. Z., Wu, C., Cochrane, B. B., Wallace, R., & Woods, N. F. (2009) Mortality Risk Associated with Physical and Verbal Abuse in Women Aged 50 to 79. *Journal of the American Geriatrics Society*, 57(10), 1799-1809.

Bartels, S. J., Miles, K. M., VanCitters, A. D., Forester, B. P., Cohen, M. J., & Xie, H. (2005). Improving Mental Health Assessment and Service Planning Practices for Older Adults: A Controlled Comparison Study. *Mental Health Services Research*, 7(4), 213-223.

Bartels, S. J., & Naslund, J. A. (2013). The Underside of the Silver Tsunami -- Older Adults and Mental Health Care. *The New England Journal of Medicine*, 368(6), 493-496.

Bass, D. M., Anetzberger, G. J., Ejaz, F. K., & Nagpaul, K. (2001). Screening Tools and Referral Protocol for Stopping Abuse Against Older Ohioans: A Guide for Service Providers. *Journal of Elder Abuse & Neglect* 13(2), 23-38.

Baumhover, L. A., & Beall, S. C. (1996). *Abuse, Neglect, and Exploitation of Older Persons: Strategies for Assessment and Intervention*. Baltimore, MD: Health Professions Press, Inc.

Beaulaurier, R. L., Seff, L., R., & Newman, F. L. (2008) Barriers to Help Seeking for Older Women Who Experienced Intimate Partner Violence: A Descriptive Model. *Journal of Women and Aging*, 20(3/4), 231–248.

Beidler, J. J. (2012). We Are Family: When Elder Abuse, Neglect, and Financial Exploitation Hit Home. *Generations*, 36(3), 21-25. 55 *The Elder Justice Roadmap—Appendices*

Benecke, M., Josephi, E., & Zweihoff, R. (2004). Neglect of the elderly: forensic entomology cases and considerations. *Forensic Science International*, 146(Suppl), S195-199.

Benton, D., & Marshall, C. (1991). Elder abuse. *Clinics in Geriatric Medicine*, 7(4), 831-845.

Berson, S. B. (2010). Prosecuting Elder Abuse Cases. *NIJ Journal*, 265, 8-9.

BITS. (2010). *BITS Fraud Protection Toolkit: Protecting the Elderly and Vulnerable from Financial Fraud and Exploitation*. Washington, DC: Author. Retrieved May 27, 2014, from http://www.giaging.org/documents/BITS_Protecting_Vulnerable_Adults.pdf.

Blancato, R. B. (2012). Elder Abuse and the Elder Justice Movement. *Generations*, 36(3), 9-11.

Blancato, R. B. (2012). Resources to Learn More About Elder Abuse. *Generations*, 36(3), 111-112.

Blowers, A. N., Davis, B., Shenk, D., Kalaw, K., Smith, M., & Jackson, K. (2012). A Multidisciplinary Approach to Detecting and Responding to Elder Mistreatment: Creating a University-Community Partnership. *American Journal of Criminal Justice*, 37(2), 276-290.

Bomba, P. A. (2006). Use of a single page elder abuse assessment and management tool: A practical clinician's approach to identifying elder mistreatment. *Journal of Gerontological Social Work*, 46(3/4), 103-122.

Bonnie, R. J., & Wallace, R. B. (Eds.). (2003). *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America*. Washington, DC: The National Academies Press.

Bonomi, A. E., Anderson, M. L., Reid, R. J., Carrell, D., Fishman, P. A., Rivara, F. P., & Thompson, R. S. (2007). Intimate Partner Violence in Older Women. *The Gerontologist*, 47(1), 34-41.

Brandl, B., Dyer, C. B., Heisler, C. J., Otto, J. M., Stiegel L. A., & Thomas, R. W. (Eds.). (2007). *Elder Abuse Detection and Intervention: A Collaborative Approach*. New York, NY: Springer Publishing Co., LLC.

Brandl, B., & Raymond, J. A. (2012). Policy Implications of Recognizing that Caregiver Stress is Not the Primary Cause of Elder Abuse. *Generations*, 36(3), 32-39.

Brandl, B., & Raymond, J. (1997). Unrecognized Elder Abuse Victims. *Older Abused Women. Journal of Case Management*, 6(2), 62-68.

Brandl, B., & Santoro, S. (2012). *Elder Abuse Training for Law Enforcement [curriculum]*. For more information, contact ncall@wcadv.org.

Brandl, B., & Turner, A. (2012). *Abuse in Later life: Cross-Training for Victim Service Providers [curriculum]*. For more information, contact ncall@wcadv.org. *The Elder Justice Roadmap—Appendices 56*

Brank, E. M., Wylie, L. E., & Hamm, J. A. (2012). Potential for Self-Reporting of Older Adult Maltreatment: An Empirical Examination. *The Elder Law Journal*, 19, 351-384.

Breckman, R., S. & Adelman, R. D. (1988) *Strategies for Helping Victims of Elder Mistreatment*. Newbury Park, CA: Sage.

Brinig, M., Jogerst, G., Daly, J., Dawson, J., & Schmuck, G. (2005). Lawmaking by public welfare professionals. *Whittier Journal of Child and Family Advocacy*, 5(1), 57-86.

Brogdon, B. G. (1998). *Forensic Radiology*. Boca Raton, FL: CRC Press.

Brossoie, N., Roberto, K. A., & Barrow, K. M. (2012). Making Sense of Intimate Partner Violence in Late Life: Comments from Online News Readers. *The Gerontologist*, 52(6), 792-801.

Bueno, J. (2003). Reforming Durable Power of Attorney Statutes to Combat Financial Exploitation of the Elderly. *NAELA Quarterly – The Journal of the National Academy of Elder Law Attorneys*, 16(4), 20-26.

Burgess, A. W., Brown, K., Bell, K., Ledray, L. E., & Poarch, J. C. (2005). Sexual abuse of older adults: Assessing for signs of a serious crime-and reporting it. *American Journal of Nursing*, 105(10), 66-71.

Burgess, A. W., Hanrahan, N. P., & Baker, T. (2005). Forensic Markers in Elder Female Sexual Abuse Cases. *Clinics in Geriatric Medicine*, 21(2), 399-412.

Burke, M. P., Olumbe, A. K., & Opeskin, K. (1998). Postmortem extravasation of blood potentially simulating antemortem bruising. *The American Journal of Forensic Medicine and Pathology*, 19(1), 46- 49.

Busby, F. (2010). A Nation-Wide Elder and Handicapped Abuse Help-Line Network – Call Us and Help Stamp Out Abuse Now. *Ageing International*, 35(3), 228-234.

Calvo, J. C. (2002). Reforming durable power of attorney statutes to combat financial exploitation of the elderly. *Bifocal*, 24(2), 1, 8-10, 12.

Cambridge, P., & Parkes, T. (2006). The Management and Practice of Joint Adult Protection Investigations between Health and Social Services: Issues Arising from a Training Intervention. *Social Work Education*, 25(8), 824-837.

Chang, V. N., & Greene, R. (2003). Study of Service Delivery by Community Mental Health Centers as Perceived by Adult Protective Services Investigator. *Journal of Elder Abuse & Neglect*, 13(3), 25-42.

Chen, E. A., Twomey, M. S., & Eliason, S. W. (2012). The National Center on Elder Abuse: Helping America's Elders to Live with Safety, Dignity, and Independence. *Generations*, 36(3), 103-105.

Choi, N. G., Kim, J., & Asseff, J. (2009). Self-Neglect and Neglect of Vulnerable Older Adults: Reexamination of Etiology. *Journal of Gerontological Social Work*, 52(2), 171-187.
57 The Elder Justice Roadmap–Appendices

Cohen, M. (2011). Screening Tools for the Identification of Elder Abuse. *Journal of Clinical Outcomes Management*, 18(6), 261-270.

Coker, J., & Little, B. (1997). Investing in the Future: Protecting the Elderly From Financial Abuse. *FBI Law Enforcement Bulletin*, 66(12), 1-5.

Collins, K. A., & Presnell, S. E. (2006). Elder Homicide: A 20-Year Study. *American Journal of Forensic Medicine and Pathology*, 27(2), 183-187.

Collins, K. A., & Presnell, S. E. (2007). Elder Neglect and the Pathophysiology of Aging. *The American Journal of Forensic Medicine and Pathology*, 28(2), 157-162.

Collins, K. A., & Sellars, S. E. (2005). Vertebral Artery Laceration Mimicking Elder Abuse. *The American Journal of Forensic Medicine and Pathology*, 26(2), 150-154.

Connolly, M. T. (2002). Federal Law Enforcement in Long Term Care. *Journal of Health Care Law and Policy*, 4(2), 230-293.

Connolly, M. T. (2012). High-Cost Blind Spot. *Public Policy and Aging Report*, 22(1), 8.

Connolly, M. T. (2012). How Change Happens. *Temple Political & Civil Rights Law Review*, 21(2), 329 ff.

Connolly, M. T. (2010). Where Elder Abuse and the Justice System Collide: Police Power, *Parens Patrie*, and Twelve Recommendations. *Journal of Elder Abuse & Neglect*, 22(1/2), 37-93.

Connolly, M. T., Breckman, R., Callahan, J., Lachs, M. S., Ramsey-Klawnsnik, H., & Solomon, J. (2012). The sexual revolution's last frontier: How silence about sex undermines health, well-being, and safety in old age. *Generations*, 36(3), 43-52.

Conroy, A. J. (2009). Curbing the license to steal: a discussion of English law and possible reforms for the durable power of attorney. *Real Property Trust & Estates Law Journal*, 44, 31-53.

Cooney, C., Howard, R., & Lawlor, B. (2006). Abuse of vulnerable people with dementia by their carers: Can we identify those most at risk? *International Journal of Geriatric Psychiatry*, 21(6), 564-571.

Cooper, C., Selwood, A., & Livingston, G. (2009). Knowledge, Detection, and Reporting of Abuse by Health and Social Care Professionals: A Systematic Review. *American Journal of Geriatric Psychiatry*, 17(10), 826-838.

Crane, J. (2000). Injury Interpretation. In M. M. Stark (Ed.), *A Physician's Guide to Clinical Forensic Medicine* (pp. 99-116). Totowa, NJ: Humana Press. *The Elder Justice Roadmap—Appendices* 58

Curtis, L. (2006). Partnering with faith communities to provide elder fraud prevention, intervention and victim services. Washington DC: Office for Victims of Crime. Retrieved May 27, 2014, from http://www.ovc.gov/publications/bulletins/elderfraud_case/welcome.html.

Daly, J. M. (2011). Evidence-Based Practice Guideline: Elder Abuse Prevention. *Gerontological Nursing*, 37(11), 11-17.

Daly, J. M., Merchant, M. L., & Jogerst, G. J. (2011). Elder Abuse Research: A Systematic Review. *Journal of Elder Abuse & Neglect*, 23(4), 348-365.

Dauenhauer, J. A., Mayer, K. C., & Mason, A. (2007). Evaluation of Adult Protective Services: Perspectives of community professionals. *Journal of Elder Abuse & Neglect*, 19(3/4), 41-57.

Dawson, L. (2010). Verbalee's Experience: Cross-Training on a Coordinated Community Response to Elder Abuse [curriculum]. For more information, contact ncall@wcadv.org.

Deevy, M., Lucich, S., & Beals, M. (2012). Scams, Schemes and Swindles: A Review of Consumer Financial Fraud Research. Stanford, CA: Financial Fraud Research Center. Retrieved May 27, 2014, from <http://fraudresearchcenter.org/>.

De Letter, E. A., Vandekerkhove, B. N. W., Lambert, W. E., Van Varenbergh, D., & Piette, M. H. A. (2008). Hospital bed related fatalities: a review. *Medicine, Science and the Law*, 48(1), 37-50.

Desmarais, S. L., & Reeves, K. A. (2007). Gray, Black, and Blue: The State of Research and Intervention for Intimate Partner Abuse Among Elders. *Behavioral Sciences and the Law*, 25(3), 377-391.

Dessin, C. (2005). Elder law: Should attorneys have a duty to report financial abuse of the elderly. *Akron Law Review*, 38, 707-723.

Dietz, T. L., & Wright, J. D. (2005). Age and gender differences and predictors of victimization of the older homeless. *Journal of Elder Abuse & Neglect*, 17(1), 37-60.

Di Maio, V. J., & Di Maio, T. G. (2002). Homicide by decubitus ulcer. *American Journal of Forensic Medicine and Pathology*, 23(1), 1-4.

Dolinak, D., Matshes, E., & Lew, E. O. (2005). *Forensic Pathology: Principles and Practice*. London: Academic Press.

Dong, X. (2012). Building the Foundation to Prevent Elder Abuse: Cultural Diversity and the Role of Community. White Paper submitted to the Elder Justice Coordinating Council. Retrieved May 27, 2014, from [http://www.aoa.gov/AoA_programs/Elder_Rights/EJCC/docs/](http://www.aoa.gov/AoA_programs/Elder_Rights/EJCC/docs/Dong_White_Paper.pdf)

Dong_White_Paper.pdf. Dong, X. Q. (2012). Culture Diversity and Elder Abuse: Implications for Research, Education, and Policy. *Generations*, 36(3), 40-42. 59 The Elder Justice Roadmap—Appendices

Dong, X. Q., Chang, E. S., Wong, E., Wong, B., & Simon, M. A. (2011). How Do U.S. Chinese Older Adults View Elder Mistreatment? Findings From a Community-Based Participatory Research Study. *Journal of Aging and Health, 23*(2), 289-312.

Dong, X., Simon, M., Beck, T., & Evans, D. (2010). A cross-sectional population-based study of elder self-neglect and psychological, health, and social factors in a biracial community. *Aging & Mental Health, 14*(1), 74-84.

Dong, X. Q., Simon, M. A., Beck, T. T., Farran, C., McCann, J. J., Mendes de Leon, C. F., Laumann, E., & Evans, D. A. (2010). Elder Abuse and Mortality: The Role of Psychological and Social Wellbeing. *Gerontology, 57*(6), 549-558.

Dong X., Simon M. A., & Gorbien M. (2007). Elder Abuse and Neglect in an Urban Chinese Population. *Journal of Elder Abuse & Neglect, 19*(3/4), 79-96.

Dubble, C. (2006). A Policy Perspective on Elder Justice Through APS and Law Enforcement Collaboration. *Journal of Gerontological Social Work, 46*(3/4), 35-55.

Dyer, C. B. How Can We Identify the Physical and Psychological Markers of Abuse and Neglect? How Should We Educate the Healthcare Professional about these Forensic Issues? Paper prepared for Medical Forensic Issues Concerning Abuse and Neglect, Washington, DC. Retrieved from <http://www.nij.gov/topics/crime/elder-abuse/roundtable/short-papers.htm>.

Dyer, C. B. (2005). Neglect assessment in elderly persons. *The Journals of Gerontology: Series A Biological Sciences & Medical Sciences, 60*(8), 1000-1001.

Dyer, C. B., Gleason, M. S., Murphy, K. P., Pavlik, V. N., Portal, B., Regev, T., & Hyman, D. J. Treating elder neglect: A Collaboration Between a Geriatrics Assessment Team and Adult Protective Services. *Southern Medical Journal, 92*(2), 242-244.

Dyer, C. B., Pavlik, V. N., Murphy, K. P., & Hyman, D. J. The High Prevalence of Depression and Dementia in Elder Abuse or Neglect. *Journal of the American Geriatrics Society, 48*(2), 205-208.

Dyer, C. B., Toronjo, C., Cunningham, M., Festa, N. A., Pavlik, V. N., Hyman, D. J., Poythress, E. L., & Searle, N. S. (2006). The key elements of elder neglect: a survey of Adult Protective Service workers. *Journal of Elder Abuse & Neglect, 17*(4), 1-10.

Eisendrath, B. Reimagining the Ombudsman: An Appraisal: An Ombudsman Program Can Serve as a Useful Alternative to the Court System for Nursing Home Residents. *Elder's Advisor, 3*(3), 49-61.

Ejaz, F. K., Bass, D. M., Anetzberger, G. J., & Nagpaul, K. (2001). Evaluating the Ohio Elder Abuse and Domestic Violence in Late Life Screening Tools. *Journal of Elder Abuse & Neglect*, 13(2), 39-57.

Ernst, J. S., & Smith, C. A. (2012). Assessment in Adult Protective Services: Do Multidisciplinary Teams Make a Difference? *Journal of Gerontological Social Work*, 55(1), 21-38.
The Elder Justice Roadmap—Appendices 60

Estes, C., Lohrer, S., Goldberg, S., Grossman, B. R., Nelson, M., Koren, M. J., & Hollister, B. Factors Associated with Perceived Effectiveness of Local Long-Term Care Ombudsman Programs in New York and California. *Journal of Aging and Health*, 22(6), 772-803.

Estes, C. L., Zulman, D. M., Goldberg, S. C., & Ogawa, D. D. (2004). State Long Term Care Ombudsman Programs: Factors Associated with Perceived Effectiveness. *The Gerontologist*, 44(1), 104-115.

Falk, E., Landsverk, E., Mosqueda, L., Olsen, B. J., Schneider, D. C., Bernatz, S., & Wood S. (2010). Geriatricians and psychologists: essential ingredients in the evaluation of elder abuse and neglect. *Journal of Elder Abuse & Neglect*, 22(3/4), 281-290.

Falzon, A. L., & Davis, G. G. A 15 year retrospective review of homicide in the elderly. *Journal of Forensic Sciences*, 43(2), 371-374.

Family Violence Prevention Fund. The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. Retrieved from http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_consensus_guidelines.

Federman, J., & Reed, M. (2006). Abuse and durable power of attorney: Options for reform. Albany, NY: Government Law Center of Albany Law School.

Filinson, R. An Evaluation of a Program of Volunteer Advocates for Elder Abuse Victims. *Journal of Elder Abuse & Neglect*, 5(1), 77-94.

Filinson, R. A Survey of Grass Roots Advocacy Organization for Nursing Home Residents. *Journal of Elder Abuse & Neglect*, 7(4), 75-91.

FINRA Investor Education Foundation. (Producer). (2010). Tricks of the Trade: Outsmarting Investment Fraud. [DVD]. Washington, DC: Author.

Fisher, B. S., & Regan, S. L. (2006). The extent and frequency of abuse in the lives of older women and their relationship with health outcomes. *The Gerontologist*. 46(2), 200-209.

Freeman, I. C. (2010). *Identifying and Intervening in Financial Exploitation: A Manual for Providers Serving Vulnerable Adults in Congregate Settings*. St. Paul, MN: Center for Elder Justice and Policy, William Mitchell College of Law.

Frolik, L. (2002). Promoting Judicial Acceptance and Use of Limited Guardianship. *Stetson Law Review* 31, 735-755. 61 *The Elder Justice Roadmap—Appendices*

Fulmer, T. (2008). Barriers to Neglect and Self-Neglect Research. *Journal of the American Geriatrics Society*, 56(s2), S241-S243.

Fulmer, T., Firpo, A., Guadagno, L., Easter, T. M., Kahan, F., & Paris, B. Themes from a Grounded Analysis of Elder Neglect Assessment by Experts. *The Gerontologist*, 43(5), 745-752.

Fulmer, T., Guadagno, L., Dyer, C., & Connolly, M. T. Progress in elder abuse assessment instruments. *Journal of the American Geriatrics Society*, 52(2), 297–304.

Fulmer, T., Paveza, G., VandeWeerd, C., Fairchild, S., Guadagno, L. Bolton-Blatt, M., & Norman, R. Dyadic Vulnerability and Risk Profiling for Elder Neglect. *The Gerontologist*, 45(4), 525-534.

Fulmer, T., Paveza, G., Vandeweerd, C., Guadagno, L., Fairchild, S., Norman, R., Abraham, I., & BoltonBlatt, M. (2005). Neglect assessment in urban emergency departments and confirmation by an expert clinical team. *The Journals of Gerontology. Series A: Biological Sciences and Medical Sciences*, 60(8), 1002-1006.

Geroff, A. J., & Olshaker, J. S. (2006). Elder abuse. *Emergency Medicine Clinics of North America*, 24(2), 491-505.

Gibbons, S., Lauder, W., & Ludwick, R. (2006). Self-Neglect: A Proposed New NANDA Diagnosis. *International Journal of Nursing Terminologies and Classifications*, 17(1), 10-18.

Gibson, S. C., & Qualls, S. H. (2012). A Family Systems Perspective of Elder Financial Abuse. *Generations*, 36(3), 26-29.

Gironda, M. W., Lefever, K., Delagrammatikas, L., Nerenberg, L., Roth, R., Chen, E. A., & Northington, K. R. (2010). Education and Training of Mandated Reporters: Innovative Models, Overcoming Challenges, and Lessons Learned. *Journal of Elder Abuse & Neglect*, 22(3/4), 340-364.

Gitlin, L. N., & Schulz, R. (2012). Family Caregiving of Older Adults. In T. R. Prohaska, L. A. Anderson, & R. H. Binstock (Eds.), *Public Health for an Aging Society* (pp. 181-204). Baltimore, MD: Johns Hopkins University Press.

Gitlin, L. N., & Wolff, J. (2011) Family Involvement in Care Transitions of Older Adults: What Do We Know and Where Do We Go From Here? *Annual Review of Gerontology and Geriatrics*, 31(1), 31-64. New York, NY: Springer Publishing Company. The Elder Justice Roadmap—Appendices 62

Goergen, T., & Beaulieu, M. (2013). Critical concepts in elder abuse research. *International Psychogeriatrics*, 25(8), 1217-1228.

Golden, G. S. (2004). Forensic odontology and elder abuse -- a case study. *Journal of the California Dental Association*, 32(4), 336-340.

Greenbaum, A. R., Horton, J. B., Williams, C. J., Shah, M., & Dunn, K. W. (2006). Burn Injuries Inflicted on Children or the Elderly: A Framework for Clinical and Forensic Assessment. *Plastic and Reconstructive Surgery*, 118(2), 46e-58e.

Greenlee, K. (2012). Take a Stand Against Elder Abuse. *Generations*, 36(3), 6-8.

Greenwood, P. Prosecuting Elder Abuse: A Toolkit. Paper presented at an Adult Protective Services Conference in San Antonio, Texas, November 8, 2001.

Groves, B. M., Augustyn, M., Lee, D., & Sawires, P. Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health. Retrieved from http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_consensus_recommendations.

Guion, L. A., Turner, J., & Wise, D. K. (2004). Design, Implementation, and Evaluation of an Elder Financial Abuse Program. *Journal of Extension*, 42(3). Retrieved May 27, 2014, from <http://www.joe.org/joe/2004june/a6.php>.

Gunther, J. (2011). The Utah Cost of Financial Exploitation. Salt Lake City, UT: Utah Division of Aging and Adult Services. Retrieved May 27, 2014, from http://vtdigger.org/vtdNewsMachine/wpcontent/uploads/2011/08/20110807_utahCosts.pdf.

Harbison, J., Coughlan, S., Karbanow, J., & VanderPlaat, M. (2005). A clash of cultures: Rural values and service delivery to mistreated and neglected older people in eastern Canada. *Practice*, 17(4), 229-246.

Harrell, R., Toronjo, C. H., McLaughlin, J., Pavlik, V. N., Hyman, D. J., & Dyer, C. B. How Geriatricians Identify Elder Abuse and Neglect. *The American Journal of Medical Sciences*, 323(1), 34- 38.

Harwell, C. (2011). Practical Legal Guide on Sexual Assault and Sexual Abuse for Caregivers.

Albuquerque, NM: New Mexico Coalition of Sexual Assault Programs, Inc.

Hawes, C., Blevins, D., & Shanley, L. (2003). Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries. Report to the Centers for Medicare & Medicaid Services. College Station, TX: Program in Aging and Long-Term Care Policy, School of Rural Public Health, Texas A&M Health Science Center.

Hawes, C., & Kimbell, A. M. (2009). Detecting, Addressing and Preventing Elder Abuse In Residential Care Facilities. Report to the National Institute of Justice. College Station, TX: Program in Aging and The Elder Justice Roadmap—Appendices Long-Term Care Policy, School of Rural Public Health, Texas A&M Health Science Center. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/229299.pdf>.

Hayashi, T., Ago, K., Ago, M., Yamanouchi, H., Bunai, Y., & Ogata, M. (2010). The infiltration of ‘primed’ neutrophils into multiple organs due to physical abuse to the elderly; An immunohistochemical study. *Forensic Science International*, 202(1), 17-25.

Hayashi, T., Bunai, Y., Ago, K., Ago, M., & Ogata, M. (2011). Thymus and Adrenal Glands in Elder Abuse. *American Journal of Forensic Medicine & Pathology*, 32(4), 368-371.

Heath, J. M., Dyer, C. B., Kerzner, L. J., Mosqueda, L., & Murphy, C. (2002). Four Models of Medical Education about Elder Mistreatment. *Academic Medicine*, 77(11), 1101-1106.

Heath, J. M., Kobylarz, F. A., Brown, M., & Castaño, S. (2005). Interventions from home-based assessments of adult protective service clients suffering elder mistreatment. *Journal of the American Geriatrics Society*, 53(9), 1538-1542.

Heisler, C. The Criminal Justice System and Healthcare Professionals: A Critical Collaboration to Protect Victims and Detect Abuse and Neglect. Paper presented at Elder Justice: Medical Forensic Issues Concerning Abuse and Neglect, Washington, DC. Retrieved from <http://www.nij.gov/topics/crime/elder-abuse/roundtable/short-papers.htm>.

Heisler, C. J. (2012). Elder Abuse and the Criminal Justice System: An Uncertain Future. *Generations*, 36(3), 83-88.

Heisler, C. J., & Bolton, Q. D. (2006). Self-Neglect: Implications for Prosecutors. *Journal of Elder Abuse & Neglect*, 18(4), 93-102.

Heisler, C. J., & Stiegel, L. A. (2004). Enhancing the Justice System’s Response to Elder Abuse: Discussions and Recommendations of the “Improving Prosecution” Working Group of the National Policy Summit on Elder Abuse. *Journal of Elder Abuse & Neglect*, 14(4), 31-54.

- Hightower, J., Smith, M. J., & Hightower, H. C. (2006). Hearing the voices of abused older women. *Journal of Gerontological Social Work*, 46(3/4), 205-227.
- Hollister, B. A., & Estes, C. L. (2013). Local Long-Term Care Ombudsman Program Effectiveness and the Measurement of Program Resources. *Journal of Applied Gerontology*, 32(6), 708-728.
- Hoyt, C. A. (2006). Integrating Forensic Science into Nursing Processes in the ICU. *Critical Care Nursing Quarterly*, 29(3), 259-270.
- Huber, R., Borders, K. W., Badrak, K., Netting, F. E., & Nelson, H. W. (2001). National Standards for the Long-Term Care Ombudsman Program and a Tool to Assess Compliance: The Huber Badrak Borders Scales. *The Gerontologist*, 41(2), 264-271.
- Huber, R., Borders, K., Netting, F. E., & Nelson, H. W. (2001). Data from long-term care ombudsman programs in six states: the implications of collecting resident demographics. *The Gerontologist*, 41(1), 61- 68.
- Hughes, V. K., Ellis, P. S., & Langlois, N. E. J. (2004). The perception of yellow in bruises. *Journal of Clinical Forensic Medicine*, 11(5), 257-259.
- Hurme, S., & Wood, E. (2002). Guardian Accountability Then and Now: Tracing Tenets for an Active Court Role. *Stetson Law Review*, 31, 867-940.
- Imbody, B., & Vandsburger, E. (2011). Elder Abuse and Neglect: Assessment Tools, Interventions, and Recommendations for Effective Service Provision. *Educational Gerontology*, 37(7), 634-650.
- Ingram, E. M. (2003). Expert Panel Recommendations on Elder Mistreatment Using a Public Health Framework. *Journal of Elder Abuse & Neglect*, 15(2), 45-65. *The Elder Justice Roadmap—Appendices*
- International Association of Forensic Nurses & Office for Victims of Crime. (2010). *Nursing Response to Elder Mistreatment Curriculum*. Retrieved from <http://www.iafn.org/displaycommon.cfm?an=1&subarticlenbr=459>.
- International Longevity Center. Anti-Ageism Task Force. (2006). *Ageism in America*. New York, NY: International Longevity Center-USA.
- Jackson, S. L., & Hafemeister, T. L. (2012). Pure Financial Exploitation vs. Hybrid Financial Exploitation Co-Occurring With Physical Abuse and/or Neglect of Elderly Persons. *Psychology of Violence*, 2(3), 285- 296.

Jogerst G., Daly J., & Hartz, A. (2005). Ombudsman Program Characteristics Related to Nursing Home Abuse Reporting. *Journal of Gerontological Social Work*, 46(1), 85-98.

Johnson, T. F. (Ed.) (2007). *Handbook on Ethical Issues in Aging*. Westport, CT: Greenwood Publishing Group.

Justice for All: Ending Elder Abuse, Neglect and Exploitation: Hearing before the Senate Special Committee on Aging (Serial 112-1), 112th Cong. 147 (2011) (testimony of Marie-Therese Connolly).

Kapp, M. B. Reforming Guardianship Reform: Reflections on Disagreements, Deficits, and Responsibilities. *Stetson Law Review*, 31(3), 1047-1055.

Karp, N., & Wilson, R. (2011). *Protecting Older Investors: The Challenge of Diminished Capacity*. Washington, DC: AARP.

Karp, N., & Wood, E. (2013). *Choosing Home for Someone Else: Guardian Decisions on Long-Term Services and Supports*. Washington, DC: AARP Public Policy Institute.

Karp, N., & Wood, E. (2007). *Guarding the Guardians: Promising Practices for Court Monitoring*. Washington, DC: AARP Public Policy Institute.

Kemp, B. J., & Mosqueda, L. (2005). Elder Financial Abuse: An Evaluation Framework and Supporting Evidence. *Journal of the American Geriatrics Society*, 53(7), 1123-1127.

Kenney, J. P. (2006). Domestic violence: A complex health care issue for dentistry today. *Forensic Science International*, 159(Suppl 1), S121-S125.

Koehler, S., Shakir, A. M., & Omalu, B. I. (2006). Cause of Death among Elder Homicide Victims: A 10- Year Medical Examiner Review. *Journal of Forensic Nursing*, 2(4), 199-203.

Koehler, S. A., Weiss, H. B., Shakir, A., Shaeffer, S., Ladham, S., Rozin, L., Dominick, J., Lawrence, B. A., Miller, T. R., & Wecht, C. H. (2006). Accurately assessing elderly fall deaths using hospital discharge and vital statistics data. *American Journal of Forensic Medicine and Pathology*, 27(1), 30-35.

Koenig, T. L., Chapin, R., & Spano, R. (2010). Using Multidisciplinary Teams to Address Ethical Dilemmas With Older Adults Who Hoard. *Journal of Gerontological Social Work*, 53(2), 137-147.

Koenig, T. L., Rinfrette, E. S., & Lutz, W. A. (2006). Female Caregivers' Reflections on Ethical

Decision-Making: The Intersection of Domestic Violence and Elder Care. *Clinical Social Work Journal*, 34(3), 361-372.

Kohl, H., Sanders, B., & Blumenthal, R. (2012). Elder Abuse: What Is the Federal Role? *Generations*, 36(3), 106-110.

Kohn, N. A. (2006). Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney. *Rutgers Law Review*, 59(1), 1-53.

Kohn, N. A. (2012). Elder (In)Justice: A Critique of the Criminalization of Elder Abuse. *American Criminal Law Review*, 49(1). Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2140569.

Kohn, N. A. (2013). *Elder Law: Practice, Policy, and Problems*. New York: Aspen Publishers.

Kohn, N. A. (2012). Elder Rights: The Next Civil Rights Movement. *Temple Political & Civil Rights Law Review*, 21(2), 321 ff.

Kohn, N. A. (2009). Outliving Civil Rights. *Washington University Law Review*, 86(5), 1053-1115.

Koin, D. (2003). A Forensic Medical Examination Form for Improved Documentation and Prosecution of Elder Abuse. *Journal of Elder Abuse & Neglect*, 15(3/4), 109-119.

Kosberg, J. I. (2007). Abuse of older men [Special issue]. *Journal of Elder Abuse & Neglect*, 19(1/2), 1-5.

Krienert, J. L., Walsh, J. A., & Turner, M. (2009). Elderly in America: A Descriptive Study of Elder Abuse Examining National Incident –Based Reporting System (NIBRS) Data, 2000-2005. *Journal of Elder Abuse & Neglect* 21(4), 325-345.

Lachs, M. S., Bove, C., Wearing, M. H., Williams, C., Bachman, R., & Clooney, L. M. (2001). The Clinical Epidemiology of Crime Victimization in Older Adults: A Multidisciplinary Pilot Study. *Journal of Elder Abuse & Neglect*, 13(3), 79-90.

Lachs, M. S., & Pillemer, K. (2004). Elder abuse. *Lancet*, 364(9441), 1263-1272.

Lachs, M. S., Williams, C. S., O'Brien, S., & Pillemer, K. A. (2002). Adult Protective Service Use and Nursing Home Placement. *The Gerontologist*, 42(6), 734-739.

Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K. A., & Charlson, M. E. (1998). The Mortality of Elder Mistreatment. *Journal of the American Medical Association*, 280(5), 428-432.

Lauder, W., Anderson, I., & Barclay, A. (2005). Housing and self-neglect: The responses of health, social care and environmental health agencies. *Journal of Interprofessional Care*, 19(4), 317-325.

Laumann, E. O., Leitsch, S. A., & Waite, L. J. (2008). Elder Mistreatment in the United States: Prevalence Estimates From a Nationally Representative Study. *Journals of Gerontology: Series B, Psychological and Social Sciences*, 63(4), S248-S254.

Lea, S. J., Hunt, L., & Shaw, S. (2011). Sexual Assault of Older Women by Strangers. *Journal of Interpersonal Violence*, 26(11), 2303-2320.

Leisey, M., Kupstas, P. K., & Cooper, A. (2009). Domestic Violence in the Second Half of Life. *Journal of Elder Abuse & Neglect*, 21(2), 141-155.

Liao, S., Baker, M., Lowe, J., Austin, R., Whitney, J. D., Wiglesworth, A., Zimmerman, D., Zoromski, P., & Mosqueda, L. (2010). A Multi-Site Study to Characterize Pressure Ulcers in Long-Term Care Under Best Practices. Unpublished manuscript.

Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center, & New York City Department for the Aging. (2011). Under the Radar: New York State Elder Abuse Prevalence Study. Self-reported prevalence and documented case surveys. Final report. Rochester, NY: Author.

Lindenbach, J. M., Laroque, S., Lavoie, A-M., & Garceau, M-L. (2012). Older Adult Mistreatment Risk Screening: Contribution to the Validation of a Screening Tool in a Domestic Setting. *Canadian Journal on Aging*, 31(2), 235-252.

Lindquist, L. A., Cameron, K. A., Messerges-Bernstein, J., Friesema, E., Zickuhr, L., Baker, D. W., & Wolf, M. (2012). Hiring and Screening Practices of Agencies Supplying Paid Caregivers to Older Adults. *Journal of the American Geriatrics Society*, 60(7), 1253-1259.

Lundy, M., & Grossman, S. F. (2004). Elder Abuse: Spouse/Intimate Partner Abuse and Family Violence Among Elders. *Journal of Elder Abuse & Neglect*, 16(1), 85-102.

Luu, A. D., & Liang, B. A. (2005). Clinical case management: A strategy to coordinate detection, reporting and prosecution of elder abuse. *Cornell Journal of Law and Public Policy*, 15(1), 165-196.

Malks, B., Buckmaster, J., & Cunningham, L. (2003). Combating Elder Financial Abuse-A MultiDisciplinary Approach to a Growing Problem. *Journal of Elder Abuse & Neglect*, 15(3/4), 55-70.

Marson, D. C., Martin, R. C., Wadley, V., Griffith, H. R., Synder, S., Goode, P. S., Kinney, F. C., Nicholas, A. P., Steele, T., Anderson, B., Zamrini, E., Raman, R., Bartolucci, A., & Harrell, L. E. (2009). Clinical Interview Assessment of Financial Capacity in Older Adults with Mild Cognitive Impairment and Alzheimer's Disease. *Journal of the American Geriatrics Society*, 57(5) 806-814.

Marson, D. C., Sawrie, S. M., Snyder, S., McInturff, B., Stalvey, T., Boothe, A., Aldridge, T., Chatterjee, A., & Harrell, L. E. (2000). Assessing Financial Capacity in Patients With Alzheimer Disease: A Conceptual Model and Prototype Instrument. *JAMA Neurology*, 57(6), 877-884.

Matheson, K. (Director). (2009). *An Age for Justice: Confronting Elder Abuse in America* [DVD]. Washington, DC: National Council on Aging, WITNESS.

Mattoo, K. A., Shalabh, K., & Khan, A. (2010). Geriatric forensics: A dentist's perspective and contribution to identify existence of elder abuse among his patients. *Journal of Forensic Dental Sciences*, 2(2), 81-85.

McCartney, C. (2006). *Forensic Identification and Criminal Justice: Forensic Science, Justice and Risk*. Uffculme, Devon (UK): Willan Publishing.

Manama, C. C., & Mulford, C. (2007). *Innovations Assessment of the Elder Abuse Forensics Center of Orange County, California*. Unpublished manuscript. Retrieved <https://www.ncjrs.gov/pdffiles1/nij/grants/220331.pdf>.

Metlife Mature Market Institute. (2011). *The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation Against America's Elders*. Westport, CT: Author.

Miller, M. (2012). Ombudsmen on the Front Line: Improving Quality of Care and Preventing Abuse in Nursing Homes. *Generations*, 36(3), 60-63.

Mixson, P. M. (2010). Public policy, elder abuse, and Adult Protective Services: the struggle for coherence. *Journal of Elder Abuse & Neglect*, 22(1/2), 16-36.

Mixson, P., Dayton, C., Ramsey-Klawnsnick, H. (2012). Banding Together: The Work of a Joint Committee Yields Much-Needed Resources on Elder Abuse intervention. *Generations*, 36(3), 97-99.

Moon, A. (2000). Perceptions of Elder Abuse Among Various Cultural Groups: Similarities and Differences. *Generations*, 24(2), 75-80.

Moon, A., Lawson, K., Carpiac, M., & Spaziano, E. (2006). Elder Abuse and Neglect Among Veterans in Greater Los Angeles: Prevalence, Types and Intervention Outcomes. *Journal of Gerontological Social Work*, 46(3/4), 187-204.

Moon, A., Tomita, S. K., & Jung-Kamei, S. (2002). Elder mistreatment among four Asian American groups: an exploratory study on tolerance, victim blaming and attitudes toward third-party intervention. *Journal of Gerontological Social Work*, 36(1/2), 153-169.

Morris, J. R. (2010). The Bet Tzedek legal services model: How a legal services model addresses elder abuse and neglect. *Journal of Elder Abuse & Neglect*, 22(3/4), 275-280.

Morrissey, M. R., & Curtis, L. (2005). Partnering with Faith Communities to Prevent Elder Fraud and Exploitation. *The Prosecutor*, 39(6), 10, 12, 14, 15, 47.

Mosqueda, L. (2000, October 18). Elder Justice: Medical Forensic Issues in Elder Abuse: Attempting to Define the Issues. Paper prepared for Elder Justice: Medical Forensic Issues Concerning Abuse and Neglect, Washington, DC. Retrieved May 28, 2014, from <http://www.nij.gov/topics/crime/elderabuse/roundtable/short-papers.htm>.

Mosqueda, L. (2012). How the Federal Government Can Encourage and Facilitate the Development of Interdisciplinary Team Responses to Elder Abuse. A White Paper submitted to the Elder Justice Coordinating Council http://www.aoa.gov/AoA_programs/Elder_Rights/EJCC/docs/Mosqueda_White_Paper.pdf.

Mosqueda, L., Burnight, K., & Liao, S. (2005). The Life Cycle of Bruises in Older Adults. *Journal of the American Geriatrics Society*, 53(8), 1339-1343.

Mosqueda, L., & Wigglesworth, A. (2012). Coroner Investigations of Suspicious Elder Deaths. Unpublished manuscript <https://www.ncjrs.gov/pdffiles1/nij/grants/239923.pdf>

Mouton, C. P., Rodabough, R. J., Rovi, S. L. D., Brzyski, R. G., & Katerndahl, D. A. (2010). Psychosocial Effects of Physical and Verbal Abuse in Postmenopausal Women. *Annals of Family Medicine*, 8(3), 206-213.

Moye, J., Marson, D. C., & Edelstein, B. (2013). Assessment of capacity in an aging society. *American Psychologist*, 68(3), 158-171.

Multhaup, K. S. (2005). A multicomponent approach to teaching sensitive topics: Elder abuse as an example. *Teaching of Psychology*, 32(4), 261-263.

Mysyuk, Y., Westendorp, R. G. J., & Lindenberg, J. (2013). Added value of elder abuse definitions: A review. *Ageing Research Reviews*, 12(1), 50-57.

Nagpaul, K. (2001). Application of Elder Abuse Screening Tools and Referral Protocol: Techniques and Clinical Considerations. *Journal of Elder Abuse & Neglect*, 13(2), 59-78.

Nahmiash, D., & Reis, M. (2001). Most successful intervention strategies for abused older adults. *Journal of Elder Abuse & Neglect*, 12(3/4), 53-70.

National Adult Protective Services Resource Center & National Association of States United for Aging and Disabilities. (2012). *Adult Protective Services in 2012: Increasingly Vulnerable*. Washington, DC:

National Center for State Courts. (2012). *Elder Abuse Toolkit for Prosecutors*. Williamsburg, VA: <http://www.eldersandcourts.org/Elder-Abuse/Elder-Abuse-Standardsand-Model-Programs.aspx>.

National Center for State Courts. (2012). *Managing Elder Abuse for the Courts*. Williamsburg, VA: Author.

National Consumers League. (2005). *Telemarketing Fraud Education Toolbox*. Washington, DC:

National Consumers League. Retrieved May 28, 2014, from <http://www.fraud.org/learn/telemarketingfraud>.

National Guardianship Network. (2011). *Third National Guardianship Summit Releases Standards and Recommendations* http://www.americanbar.org/content/dam/aba/uncategorized/2011/2011_aging_gship_sumt_stmnt_1111v2.authcheckdam.pdf.

National Indian Council on Aging. (2004). *A Review of the Literature: Elder Abuse in Indian County: Research, Policy and Practice*. Washington, DC: National Center on Elder Abuse.

National Policy Summit on Elder Abuse. *National Action Agenda, 2002: Call to Action to Protect America's Most Vulnerable Elders*. *Journal of Elder Abuse & Neglect*, 14(4), 3-10.

National Research Council. (2014). *Elder Abuse and Its Prevention: Workshop Summary*. Washington, DC: The National Academies Press.

Navarro, A. E., Gassoumis, Z. D., & Wilber, K. H. (2012). Holding Abusers Accountable: An Elder Abuse Forensic Center Increases Criminal Prosecution of Financial Exploitation. *The Gerontologist*, 53(2), 303-312.

Navarro, A. E., Wilber, K. H., Yonashiro, J., & Homeier, D. C. (2010). Do We Really Need Another Meeting? Lessons From the Los Angeles County Elder Abuse Forensic Center. *The Gerontologist*, 50(5), 702-711.

Nerenberg, L. (2007). *Elder Abuse Prevention: Emerging Trends and Promising Strategies*. New York, NY: Springer Publishing Company.

Nerenberg, L. (2002). *Preventing Elder Abuse by Family Caregivers*. Washington, DC: National Center on Elder Abuse.

Nerenberg, L., Davies, M., & Navarro, A. A. (2012). In Pursuit of a Useful Framework to Champion Elder Justice. *Generations*, 36(3), 89-96.

Not Born Yesterday: How Seniors Can Stop Investment Fraud: Hearing before the Senate Special Committee on Aging (Serial 109-20), 109th Cong. (2006).

Nusbaum, N. J., Cheung, V. M., Cohen, J., Keca, M., & Mailey, B. (2006). Role of first responders in detecting and evaluating elders at risk. *Archives of Gerontology and Geriatrics*, 43(3), 361-367.

Office of Inspector General, Department of Health and Human Services. (2014). *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*. OEI-06-11-00370. Washington, DC: Author.

Otto, J., Stanis, P., & Marlatt, K. Survey Report: State Adult Protective Services Program Responses to Financial Exploitation of Vulnerable Adults. Washington, DC: National Association of Adult Protective Services Administrators.

Page, C., Conner, T., Prokhorov, A., Fang, Y., & Post, L. (2009). The effect of care setting on elder abuse: Results from a Michigan survey. *Journal of Elder Abuse & Neglect*, 21(3), 239-252.

Paranitharan, P., & Pollanen, M. S. (2009). The interaction of injury and disease in the elderly: A case report of fatal elder abuse. *Journal of Forensic and Legal Medicine*, 16(6), 346-349.

Park-Lee, E., & Caffrey, C. (2009). Pressure ulcers among nursing home residents: United States, 2004. *NCHS Data Brief*, 14, 1-8.

Paveza, G. J. (2004). The Elder Justice Bill's Impact on Research: Likely Fact or Fiction. *Journal of Elder Abuse & Neglect*, 14(2/3), 199-203.

Pavlou, M. P., & Lachs, M. S. (2006). Could self-neglect in older adults be a geriatric syndrome? *Journal of the American Geriatrics Society*, 54(5), 831-842.

Payne, B. K., & Gainey, R. R. (2005). Differentiating self-neglect as a type of elder mistreatment: How do these cases compare to traditional types of elder mistreatment. *Journal of Elder Abuse & Neglect*. 17(1), 21-36.

- Payne, B. K., & Strasser, S. M. (2012). Financial Exploitation of Older Persons in Adult Care Settings: Comparisons to Physical Abuse and the Justice System's Response. *Journal of Elder Abuse & Neglect*, 24(3), 231-250.
- Pearsall, C. (2005). Forensic Biomarkers of Elder Abuse: What Clinicians Need to Know. *Journal of Forensic Nursing*, 1(4), 182-186.
- Peck, K. R. (2012). Lifestyles of the Rich and Famous: Infamous Cases of Financial Exploitation. *Generations*, 36(3), 30-31.
- Perel-Levin, S. (2008). *Discussing Screening for Elder Abuse at Primary Health Care Level*. Geneva, Switzerland: World Health Organization.
- Persson, D. (2002). The Ombudsman Program: An Overview of the History, Purpose, and Roles of Ombudsmen in Long-Term Care Facilities. *Journal of the American Medical Directors Association*, 3(4), 270-273.
- Phelan, A. (2008). Elder abuse, ageism, human rights, and citizenship: Implications for nursing discourse. *Nursing Inquiry*, 15(4), 320-329.
- Pillemer, K., Chen, E. K., Van Haitsma, K. S., Teresi, J., Ramirez, M., Silver, S., Sukha, G., & Lachs, M. S. (2012). Resident-to-Resident Aggression in Nursing Homes: Results from a Qualitative Event Reconstruction Study. *The Gerontologist*, 52(1), 24-33.
- Pinsker, D. M., McFarland, K., & Stone, V. E. (2011). The Social Vulnerability Scale for Older Adults: An Exploratory and Confirmatory Factor Analytic Study. *Journal of Elder Abuse & Neglect*, 23(3), 246- 272.
- Pisani, D. M., McFarland, K., & Walsh, C. A. (2012). Screening for Elder Abuse in Hospitalized Older Adults with Dementia. *Journal of Elder Abuse & Neglect*, 24(3), 195-215.
- Ploeg, J., Fear J, Hutchison, B., MacMillan, H., & Bolan, G. (2009). A systematic review of interventions for elder abuse. *Journal of Elder Abuse & Neglect*, 21(3), 187-210.
- Podnieks, E., & Wilson, S. (2003). Elder Abuse Awareness in Faith Communities: Findings from a Canadian Pilot Study. *Journal of Elder Abuse & Neglect*, 15(3/4), 121-135.
- Poole, C., & Rietschin, J. (2012). Intimate Partner Victimization Among Adults Aged 60 and Older: An Analysis of the 1999 General Social Survey. *Journal of Elder Abuse & Neglect*, 24(2), 120-137.
- Quinn, K. M., & Benson, W. F. (2012). The States' Elder Abuse Victim Services: A System in Search of Support. *Generations*, 36(3), 66-72.

- Quinn, M. J. (2005). *Guardianships of Adults: Achieving Justice, Autonomy and Safety*. New York, NY: Springer Publishing Company.
- Quinn, M. J., & Heisler, C. J. (2004). The Legal Response to Elder Abuse and Neglect. *Journal of Elder Abuse & Neglect*, 14(1), 61-77.
- Rabiner, D. J., Brown, D., & O'Keefe, J. (2004). Financial exploitation of older persons: Policy issues and recommendations for addressing them. *Journal of Elder Abuse & Neglect*, 16(1), 65-84.
- Ramsey-Klawnsnik, H. (2000). Elder-Abuse Offenders: A Typology. *Generations*, 24(2), 17-22.
- Ramsey-Klawnsnik, H., & Brandl, B. (2010). Sexual Abuse in Later Life. *Family & Intimate Partner Violence Quarterly*, 3(1), 87-96.
- Ramsey-Klawnsnik, H., & Teaster, P. B. (2012). Sexual Abuse Happens in Healthcare Facilities – What Can Be Done to Prevent It? *Generations* 36(3), 53-59.
- Ramsey-Klawnsnik, H., Teaster, P. B., Mendiondo, M. S., Marcum, J. L., & Abner, E. L (2008). Sexual predators who target elders: Findings from the first national study of sexual abuse in care facilities. *Journal of Elder Abuse & Neglect*, 20(4), 353-376.
- Rantz, M. J., Vogelsmeier, A., Manion, P., Minner, D., Markway, B., Conn, V., Aud, M. A., & Mehr, D. R. (2003). Statewide Strategy to Improve Quality of Care in Nursing Facilities. *The Gerontologist*, 43(2), 248-258.
- Rath, L. (2012). Advancing the Field: The Archstone Foundation Elder Abuse and Neglect Initiative. *Generations*, 36(3), 100-102.
- Reeves, K. A., Desmarais, S. L., Nicholls, T. L., & Douglas, K. S. (2007). Intimate partner abuse of older men: considerations for the assessment of risk. *Journal of Elder Abuse & Neglect*, 19(1/2), 7-27.
- Reeves, S., & Wysong, J. (2010). Strategies to address financial abuse. *Journal of Elder Abuse & Neglect*, 22(3/4), 328-334.
- Reingold, D. A. (2006). An Elder Abuse Shelter Program: Build It and They Will Come, a Long Term Care Based Program to Address Elder Abuse in the Community. *Journal of Gerontological Social Work*, 46(3/4), 123-153.
- Robb, C., Chen, H., & Haley, W. E. (2002). Ageism in Mental Health and Health Care: A Critical Review. *Journal of Clinical Geropsychology*, 8(1), 1-12.

Roberto, K. A., McPherson, M. C., & Brossoie, N. (2014). Intimate Partner Violence in Late Life. A Review of the Empirical Literature. *Violence Against Women*, 19(12), 1538-1558.

Rosalyn Carter Institute for Caregiving. (2012). Averting the Caregiving Crisis: An Update. Americus, http://www.rosalynncarter.org/caregiving_crisis/.

Rosen, T., Lachs, M. S., Bharucha, A. J., Stevens, S. M., Teresi, J. A., Nebres, F., & Pillemer, K. (2008). Resident-to-Resident Aggression in Long-Term Care Facilities: Insights from Focus Groups of Nursing Home Residents and Staff. *Journal of the American Geriatrics Society*, 56(8), 1398–1408.

Rosen, T., Lachs, M. S., & Pillemer, K. (2010). Sexual Aggression Between Residents in Nursing Homes: Literature Synthesis of an Underrecognized Problem. *Journal of the American Geriatrics Society*, 58(10), 1970–1979.

Rosenberg, J. A. (2010). Regrettably unfair: Brooke Astor and the other elderly in New York. *Pace Law Review*, 30(3), 1004-1060.

Rosin, A., & van Dijk, Y. (2005). Subtle Ethical Dilemmas in Geriatric Management and Clinical Research. *Journal of Medical Ethics*, 31(6), 355-359.

Rubio, A. (2010). Elder Abuse and Neglect. In J. C. Troncoso, A. Rubio, & D. R. Fowler (Eds.), *Essential Forensic Neuropathology* (pp. 264-277). Baltimore, MD: Lippincott, Williams & Wilson.

Sabatino, C. P. (2011). Damage Prevention and Control for Financial Incapacity. *Journal of the American Medical Association*, 305(7), 707-708.

Safe Havens Interfaith Partnership Against Domestic Violence, & The National Clearinghouse on Abuse in Later Life. (2010). *Where Faith and Safety Meet: Faith Communities Respond to Elder Abuse*. Boston,

Sandusky, S. (2003). The Lawyer's Role in Combating the Hidden Crime of Elder Abuse. *The Elder Law Journal*, 11(2), 459 ff.

Sauvageau, A., & Hunter, B. C. (2012). Self- Neglect: Adaptation of a Clinical Tool to the Practice of the Medical Examiner. *The American Journal of Forensic Medicine and Pathology*, 33(3), 289-292.

Sauvageau, A., & Racette, S. (2006). Fatal Neglect of the Elderly by a Spouse: A Case Report. *Medicine, Science and the Law*, 46(2), 173-176.

Schechter, M., & Dougherty, D. (2009). Combating elder abuse through a lawyer/social worker

collaborative team approach: JASA Legal/Social Work Elder Abuse Prevention Program (LEAP). *Care Management Journal*, 10(2), 71-76.

Schneider, D. C., Mosqueda, L., Falk, E., & Huba, G. J. (2010). Elder Abuse Forensic Centers. *Journal of Elder Abuse & Neglect*, 22(3/4), 255-274.

Schuyler, D., & Liang, B. (2006). Reconceptualizing Elder Abuse: Treating the Disease of Senior Community Exclusion. *Annals of Health Law*, 15(2), 275-305.

Seaver, C. (1997). Muted Lives: Older Battered Women. *Journal of Elder Abuse & Neglect*, 8(2), 3-21.

Shields, L., Hunsaker, D., & Hunsaker, J. (2004). Abuse and Neglect: A Ten-Year Review of Mortality and Morbidity in our Elders in a Large Metropolitan Area. *Journal of Forensic Sciences*, 49(1), 122-127.

Shryock, S., Hunsaker, D. M., Corey, T. S., & Weakley-Jones, B. (2005). Forensic Evaluation of the Elderly. *The Journal of the Kentucky Medical Association*, 103(9), 451-455.

Sifford, K. S., & Bharucha, A. (2010). Benefits and challenges of electronic surveillance in nursing home research. *Research in Gerontological Nursing*, 3(1), 5-10.

Smith, R. (Director). (2010). Responding to Elder Abuse: What Community Corrections Should Know [DVD]. United States, Video Action Inc. under contract to Office for Victims of Crime, U.S. Department of Justice.

Smith, R. (Director). (2010). Responding to Elder Abuse: What Judges and Court Personnel Should Know [DVD]. United States, Video Action Inc. under contract to Office for Victims of Crime, U.S. Department of Justice.

Smith, R. (Director). (2010). Responding to Elder Abuse: What Law Enforcement Should Know [DVD]. United States, Video Action Inc. under contract to Office for Victims of Crime, U.S. Department of Justice.

Solomon, J., & Reingold, D. A. (2012). Creating and [sic] Elder Abuse Shelter: A Best-Practice model for NonProfit Nursing Homes. *Generations*, 36(3), 64-65.

Stiegel, L. (2010). Elder Justice Act Becomes Law, But Victory is Only Partial. *Bifocal*, 31(4), 1-2.

Stiegel, L. (2006). Recommendations for the Elder Abuse, Health, and Justice Fields About Medical Forensic Issues Related to Elder Abuse and Neglect. *Journal of Elder Abuse & Neglect*, 18(4), 41-81.

Stiegel, L. A., & Klem, E. V. (2008). *Power of Attorney Abuse: What States Can Do About It. Comparison of Current State Laws with the New Uniform Power of Attorney Act*. Washington, DC: AARP Public Policy Institute.

St. James, L. (2005). *Elder Abuse Fatality Review Teams: A Replication Manual*. Washington, DC: American Bar Association.

St. James, P. (2003). Challenges in Elder Mistreatment Programs and Policy. *Journal of Gerontological Social Work*, 36(3/4), 127-140.

Stolee, P., Hiller, L. M., Etkin, M., & McLeod, J. (2012). "Flying by the seat of our pants": Current processes to share best practices to deal with elder abuse. *Journal of Elder Abuse & Neglect*, 24(2), 179-194.

Straka, S. M., & Montminy, L. (2006). Responding to the Needs of Older Women Experiencing Domestic Violence. *Violence Against Women*, 12(3), 251-267.

Sugita, J. A., & Garrett, M. D. (2012). Elder abuse and oral health care providers: An intervention to increase knowledge and self-perceived likelihood to report. *Journal of Elder Abuse & Neglect*, 24(1), 50- 64.

Teaster, P. B. (2003). *A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services*. Washington, DC: National Center on Elder Abuse (NCEA).

Teaster, P. B., Dugar, T. A., Mendiondo, M. S., Abner, E. L., Cecil, K. A., & Otto, J. M. (2007). *The 2004 Survey of State Adult Protective Services: Abuse of Vulnerable Adults 18 Years of Age and Older*. Washington, DC: National Center on Elder Abuse. Retrieved May 28, 2014, from http://www.ncea.aoa.gov/Resources/Publication/docs/APS_2004NCEASurvey.pdf.

Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A national look at elder abuse multidisciplinary teams. *Journal of Elder Abuse & Neglect*, 15(3/4), 91-107.

Teaster, P. B., Roberto, K. A., & Dugar, T. A. (2006). Intimate Partner Violence of Rural Aging Women. *Family Relations*, 55(5), 636 -648.

Teaster, P. B., & Wangmo, T. (2010). Kentucky's Local Elder Abuse Coordinating Councils: A Model for Other States. *Journal of Elder Abuse & Neglect*, 22(1/2), 191-206.

Tetterton, S., & Farnsworth, E. (2011). Older Women and Intimate Partner Violence: Effective Interventions. *Journal of Interpersonal Violence*, 26(14), 2929-2942.

Thilges, A. A. (2000). Abuse of a Power of Attorney: Who Is More Likely To Be Punished, the Elder or the Abuser? *The Journal of the American Academy of Matrimonial Lawyers*, 16(1), 579-592.

Thompson, H., & Priest, R. (2005). Elder abuse and neglect: Considerations for mental health practitioners. *Adultspan Journal*, 4(2), 116-128.

Thunder, J. M. (2003). Quiet Killings in Medical Facilities: Detection & Prevention. *Issues in Law & Medicine*, 18(3), 211-237.

Todd, C. (2002). Practitioners Must Consider Roles as Investigators, Reporters. *ED Legal Letter*, 13(5), 49-60.

Touza, C., Prado, C., & Segura, M. P. (2012). Detection Scales for the Risk of Domestic Abuse and Self Negligent Behavior in Elder Persons (EDMA). *Journal of Elder Abuse & Neglect*, 24(4), 312-325.

Tsokos, M., Heinemann, A., & Püschel, K. (2000). Pressure sores: epidemiology, medico-legal implications and forensic argumentation concerning causality. *International Journal of Legal Medicine*, 113(5), 283-287.

Twomey, M. S., Jackson, G., Li, H., Marino, T., Melchior, L. A., Randolph, J. F., Restelli-Deits, T., & Wysong, J. (2010). The Successes and Challenges of Seven Multidisciplinary Teams. *Journal of Elder Abuse & Neglect*, 22(3/4), 291-305.

Uekert, B., Dancy, D., Peters, T., & Herman, M. (2006). Policy Paper: Report from the First National Meeting of the Elder Abuse and the Courts Working Group Meeting. Williamsburg, VA: National Center for State Courts.

Ulrey, P., & Brandl, B. (2012). Collaboration Is Essential: King County's Response to a Case of Elder Abuse and Exploitation. *Generations*, 36(3), 73-78.

U.S. Department of Health and Human Services' Children's Bureau, Office on Child Abuse and Neglect, its Child Welfare information Gateway, the FRIENDS National Resource Center for Community-Based Child Abuse Prevention, & the Center for the Study of Social Policy – Strengthening Families. (2012). 2012 Resource Guide Preventing Child Maltreatment and Promoting Well-Being: A Network for Action 2012 Resource Guide. Washington, DC: Author.

U. S. Government Accountability Office (GAO). (2013). Elder Justice. Federal Government Has Taken Some Steps but Could Do More to Combat Elder Financial Exploitation. GAO-13-626T. Washington, DC: Author http://www.giaging.org/documents/Fed_gov_do_more_prevent_financial_exploitation.pdf.

U.S. Government Accountability Office. (2012). Elder Justice: National Strategy Needed to Effectively Combat Elder Financial Exploitation. GAO-11-208. Washington, DC: Author from <http://www.gao.gov/assets/660/650074.pdf>.

U.S. Government Accountability Office. (2010). Guardianships: Cases of Financial Exploitation, Neglect, and Abuse of Seniors. GAO-10-1046. Washington, DC: Author.

U.S. Government Accountability Office. (2004). Guardianships: Collaboration Needed to Protect Incapacitated Elderly People. GAO-04-655. Washington, DC: Author.

U.S. Government Accountability Office. (2011). Incapacitated Adults: Oversight of Federal Fiduciaries and Court-Appointed Guardians Needs Improvement. GAO-11-678. Washington, DC: Author <http://www.gao.gov/new.items/d11678.pdf>.

U.S. Government Accountability Office. (2006). Long term care facilities---Information on residents who are registered sex offenders paroled for other crimes. GAO-06-326. Washington, DC: Author.

U.S. Government Accountability Office. (2011). Stronger Federal Leadership Could Enhance the Response to Elder Abuse. GAO-11-208. Washington, DC: Author. Retrieved May 28, 2014, from <http://www.gao.gov/assets/320/316224.pdf>.

U.S. Senate Special Committee on Aging. (2007). Guardianships for the Elderly: Protecting the Rights and Welfare of Seniors with Reduced Capacity. Washington, DC: Government Printing Office <http://www.guardianship.org/reports/GuTheElderJusticeRoadmap-Appendices80>

Vanden Bosch, J. (Director). (2012). He Wouldn't Turn Me Loose [DVD]. United States: Terra Nova Films.

Vanden Bosch, J. (Director). (2010). In Their Own Words [DVD]. United States: Terra Nova Films.

Vanden Bosch, J. (Director). (2009). A Mother Never Gives Up Hope: Older Mothers and Abusive Adult Sons [DVD]. United States: Terra Nova Films.

Vanden Bosch, J. (Director). (2011). Walk in Our Shoes: Working with Older Survivors of Abuse [DVD]. United States: Terra Nova Films.

VandeWeerd, C., & Paveza, G. J. (2006). Verbal Mistreatment in Older Adults: A Look at Persons with Alzheimer's Disease and Their Caregivers in the State of Florida. *Journal of Elder Abuse & Neglect*, 17(4), 11-30.

Vierthaler, K. (2008). Best practices for working with rape crisis centers to address elder sexual abuse. *Journal of Elder Abuse & Neglect*, 20(4), 306-322.

Vincent, R. B. (2000). Financial Exploitation Involving Agents Under Powers of Attorney. *Victimization of the Elderly and Disabled*, 3(1), 3-4.

Vinton, L. (2003). A Model Collaborative Project Toward Making Domestic Violence Centers Elder Ready. *Violence Against Women*, 9(12), 1504-1513.

Vladescu, D., Eveleigh, K., Ploeg, J., & Patterson, C. (2000). An evaluation of a client-centered case management program for elder abuse. *Journal of Elder Abuse & Neglect*, 11(4), 5-22.

Wagenaar, D. B., Rosenbaum, R., Page, C., & Herman, S. (2009). Elder Abuse Education in Residency Programs: How Well Are We Doing? *Academic Medicine*, 84(5), 611-618.

Wagenaar, D. B., Rosenbaum, R., Page, C., & Herman, S. (2009). Elder Abuse Education in Residency Programs: How Well Are We Doing? *Academic Medicine*, 84(5), 611-618.

Walsh, C. A., Olson, J. L., Ploeg, J., Lohfeld, L., & MacMillan, H. L. (2010). Elder Abuse and Oppression: Voices of Marginalized Elders. *Journal of Elder Abuse & Neglect*, 23(1), 17-42.

Walsh, C. A., & Yon, Y. (2012). Developing an empirical profile for elder abuse in Canada. *Journal of Elder Abuse & Neglect*, 24(2), 104-119.

Ward, D. (2000). Ageism and the abuse of older people in health and social care. *British Journal of Nursing*, 9(9), 560-563.

White, J. (2011). Enhancing Judicial Skills in Elder Abuse Cases [curriculum].

Whitton, L. (2008). The Uniform Power of Attorney Act: Striking a Balance Between Autonomy and Protection. *Phoenix Law Review*, 1, 343-364.

Widera, E., Steenpass, V., Marson, D., & Sudore, R. (2011). Finances in the older patient with cognitive impairment, "He Didn't Want Me to Take Over". *Journal of the American Medical Association*, 305(7), 698-706.

Wiglesworth, A., Austin, R., Corona, M., Schneider, D., Liao, S., Gibbs, L., & Mosqueda, L. (2009). Bruising as a Marker of Physical Elder Abuse. *Journal of the American Geriatrics Society*, 57(7), 1191-1196.

Wiglesworth, A., Kemp, B., & Mosqueda, L. (2008). Combating elder and dependent adult mistreatment: The role of the clinical psychologist. *Journal of Elder Abuse & Neglect*, 20(3), 207-230.

- Wiglesworth, A., & Mosqueda, L. (2011). People with Dementia as Witnesses to Emotional Events. Irvine, CA: University of California <https://www.ncjrs.gov/pdffiles1/nij/grants/234132.pdf>.
- Wiglesworth, A., Mosqueda, L., Burnight, K., Younglove, T., & Jeske, D. (2006). Findings From an Elder Abuse Forensic Center. *The Gerontologist*, 46(2), 277-283.
- Wiglesworth, A., Mosqueda, L., Mulnard, R., Liao, S., Gibbs, L., & Fitzgerald, W. (2010). Screening for Abuse and Neglect of People with Dementia. *Journal of the American Geriatrics Society*, 58(3), 493-500.
- Wilke, D. J., & Vinton, L. (2005). The nature and impact of domestic violence across age cohorts. *Affilia*, 20(3), 316-328.
- Williams, M. E. (2006). The Ethical Challenges of Elder Abuse (CME Course). Medscape Education. Retrieved May 28, 2014, from <http://www.medscape.org/viewarticle/532943>.
- Wood, E. F. (2006). The Availability and Utility of Interdisciplinary Data on Elder Abuse: A White Paper for the National Center on Elder Abuse. Washington, DC: National Center on Elder Abuse http://www.pjwa.com/resources/Elder_Abuse_Report.pdf.
- Wood, E. F. (2012). The Paradox of Adult Guardianship: A Solution to – and a Source for – Elder Abuse. *Generations*, 36(3), 79-82.
- Wood, E. (2012). State Guardianship Legislation: Directions of Reform - 2012. Washington, DC American Bar Association Commission on Law and Aging.
- Yaffe, M. J., Weiss, D., & Lithwick, M. (2012). Seniors' Self-Administration of the Elder Abuse Suspicion Index (EASI): A Feasibility Study. *Journal of Elder Abuse & Neglect*, 24(4,) 277-292.
- Yaffe, M. J., Wolfson, C., Lithwick, M., & Weiss, D. (2008). Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). *Journal of Elder Abuse & Neglect*, 20(3), 276-300.
- Yan, E., & Kwok, T. (2011). Abuse of older Chinese with dementia by family caregivers: An inquiry into the role of caregiver burden. *International Journal of Geriatric Psychiatry*, 26(5), 527-535.

Ziminski, C. E., Phillips, L. R., & Woods, D. L. (2012). Raising the Index of Suspicion for Elder Abuse: Cognitive Impairment, Falls, and Injury Patterns in the Emergency Department. *Geriatric Nursing*, 33(2), 105-112.

Zink, T., Jacobson, C. J., Pabst, S., Regan, S., & Fisher, B. S. (2006). A Lifetime of Intimate Partner Violence: Coping Strategies of Older Women. *Journal of Interpersonal Violence*, 21(5), 634-651.

Zink, T., Regan, S., Jacobson, C. J. Jr., & Pabst, S. (2003). Cohort, Period and Aging Effects: A Qualitative Study of Older Women's Reasons for Remaining in Abusive Relationships. *Violence Against Women*, 9(12), 1429-1441.

Elder Justice Road Map References:

Neglect of Nursing Home Residents. Atlanta, GA: Author. Retrieved May 27, 2014, from <http://www.atlantalegalaid.org/abuse.htm>; Harrington, C., Carillo, H., Blank, B. W., & O'Brien, T. (2010).

Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2004-2009. San Francisco: Department of Social and Behavioral Sciences, University of California. Retrieved May 27, 2014, from http://www.pascenter.org/documents/OSCAR_complete_2010.pdf. See also, additional reports authored by the U.S. General Accountability Office and the HHS Office of Inspector General relating to facilities. Office of Inspector General, Department of Health and Human Services. (1990). Resident abuse in nursing homes: Understanding and preventing abuse. (OEI-06-88-00360.) Washington, D.C.:

Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (2003). State Ombudsman Data: Nursing Home Complaints. (OEI-09-02-00160). Washington, D.C.:

Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (2013).

Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring. (OEI-06-11-00040.) Washington, DC: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (2006).

Nursing Home Complaint Investigations. (OEI-01-04-00340.) Washington, DC: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (1999). Nursing Home Survey and Certification: Deficiency Trends. (OEI-02-98-00331.) Washington, D.C.: Department of Health and Human Services; Nursing

Home Deficiency Trends and Survey and Certification Process Consistency. (OEI-02-01-00600.) Washington, DC: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (2008).

Trends in Nursing Home Deficiencies and Complaints. (OEI-02-08-00140.) Washington, D.C.: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services.

Quality of Care in Nursing Homes: An Overview. (OEI-02-99-00060.) Washington, DC: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (1990). Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints. (OEI-06-88-00361.)

Washington, DC: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (1998). Safeguarding Long-Term Care Residents. (A-12-97-00003.) Washington, DC: Department of Health and Human Services; Office of Inspector General, Department of Health and Human Services. (1999). Long Term Care Ombudsman Program: Complaints Trends. (OEI-02-98-00350.) Washington, DC, Department of Health and Human Services, Office of Inspector General, Department of Health and Human Services. (2014).

Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries. (OEI-06-11-00370.) Washington, DC: Department of Health and Human Services. HHS Office of Inspector General (OIG) has cited almost 3,000 reports addressing mostly facility issues; this endnote can not capture them all. See OIG website at <http://oig.hhs.gov/>. This note does not include reports about hospices, psychotropic drugs, specific settlements by DOJ or HHS or OIG's Corporate Integrity Agreements. In non-nursing home facilities: Hawes, C. & Kimball, A. M. (2010).

Detecting, Addressing, and Preventing Elder Abuse in Residential Care Facilities: Report to the National Institute of Justice. Retrieved May 27, 2014, from www.ncjrs.gov/pdffiles1/nij/grants/229299.pdf; Philips, L., & Guo, G. (2011). Mistreatment in Assisted Living Facilities: Complaints, Substantiations, and Risk Factors. *The Gerontologist*, 51(3), 343-353; Castle, N. (2013).

An Examination of Resident Abuse in Assisted Living Facilities. Final Report to the National Institute of Justice. Retrieved May 27, 2014, from <https://www.ncjrs.gov/pdffiles1/nij/grants/241611.pdf>; Castle, N. G. & Beach, S. (2013).

Elder Abuse in Assisted Living. *Journal of Applied Gerontology*, 32(2), 248-267, concluding, "We could not objectively verify the cases of abuse described in the survey, still, they give a first indication that staff abuse may occur in AL. This may be significant given the

large number of ALs in the United States and may influence the health, quality of life, and safety of many residents”; Castle, N. G., Ferguson-Rome, J., & Teresi, J. A. (2013).

Elder abuse in residential long-term care: An update to the 2003 National Research Council Report. *Journal of Applied Gerontology*, (just published).

Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging. (2011).

Under the radar: New York State Elder Abuse Prevalence Study. Self-reported prevalence and documented case surveys [Final Report]. Retrieved March 24, 2014, from <http://www.lifespan-roch.org/documents/UndertheRadar051211.pdf>. (p. 5, 42). Beach, S. R., Schulz, R., Castle, N. G., & Rosen, J. (2010).

Financial exploitation and psychological mistreatment among older adults: Differences between African Americans and non-African Americans in a population-based survey. *The Gerontologist*, 50(6), 744-757; Smith, D. B., Feng, Z, Fennell, M. L., Zinn, J. S., & Mor, V. (2007). Separate and Unequal: Racial Segregation In Quality Across U. S. Nursing Homes. *Health Affairs*, 26(5), 1448-1458; see also Zuckerman, I. H., Ryder, P. T., Simoni-Wastila, L., Shaffer, T., Sato, M., Zhao, L., & Stuart, B. (2008).

DeLiema, M., Gassoumis, Z. D., Homeier, D. C., & Wilber, K. H. (2012). Determining prevalence and correlates of elder abuse using promotores: low-income immigrant Latinos report high rates of abuse and neglect. *Journal of the American Geriatric Society*, 60(7), 1333-1339.

Lachs, M., Williams, C., O'Brien, S., Hurst, L., & Horwitz, R. (1997). Risk Factors for Reported Elder Abuse and Neglect: A Nine-Year Observational Cohort Study. *The Gerontologist*, 37(4), 469-474; Johannesen, M. & LoGuidice, D. (2013). Elder abuse: A Systematic Review of Risk Factors in Community-Dwelling Elders. *Age & Ageing*, 42(3), 292-298.

Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging. (2011). Under the radar: New York State Elder Abuse Prevalence Study. Self reported prevalence and documented case surveys [Final Report]. Retrieved March 24, 2014, from <http://www.lifespan-roch.org/documents/UndertheRadar051211.pdf>. (p. 52).

Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K.A., & Charlson, M. E. (1998). The mortality of elder mistreatment. *Journal of the American Medical Association*, 280(5), 428-432. (p. 431).

Lachs, M., Williams, C. S., O'Brien, S., & Pillemer, K. (2002). Adult Protective Service use and nursing home placement. *The Gerontologist*, 42(6), 734-739. (pp. 736-737).

Dong, X. Q., & Simon, M. A. (2013). Elder abuse as a risk factor for hospitalization in older persons. *JAMA Internal Medicine*, 173(10), 911-917.

Centers for Medicare and Medicaid Services. (2001). *Appropriateness of Minimum Nurse Staff Ratios in Nursing Homes, Phase II Final Report*. Baltimore, MD: Author.(pp. 1-7)

Office of Inspector General, Department of Health and Human Services. (2014). *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*. (OEI-06-11-00370.) Washington, DC: Department of Health and Human Services.; see also, Office of Inspector General, Department of Health and Human Services. (2014). *Medicaid Fraud Control Units Fiscal Year 2013 Annual Report*. (OEI- 06-13-00340). Washington, DC: Department of Health and Human Services.

Gunther, J. (2011). *The Utah cost of financial exploitation*. Salt Lake City, UT: Utah Division of Aging and Adult Services. Retrieved March 12, 2014, from www.dhs.utah.gov/pdf/utah-financial-exploitation-study.pdf. Gunther, J. (2012). *The 2010 Utah Cost of Financial Exploitation*. Salt Lake City, UT: Utah Division of Aging and Adult Services.

Fulmer, T., Rodgers, R. F., & Pelger, A. (2013). Verbal Mistreatment of the Elderly. *Journal of Elder Abuse & Neglect*, 26(4), 351-364; Mouton, C. P., Rodabough, R. J., Rovi, S. L. D., Robert, G., Brzyski, R. J., &

Katerndahl, D. A. (2010). Psychosocial Effects of Physical and Mental Abuse in Post-Menopausal Women. *Annals of Family Medicine*, 8, 206-213.

Schulz, R., & Beach, S Caregiving as a Risk Factor for Mortality: The Caregiver Health Affects Study. *JAMA*, 282(23), 2215-2219 (reporting that participants who were providing care and experiencing caregiver strain had mortality risks that were 63% higher than noncaregiving controls); MetLife Mature Market Institute. (2011). *The MetLife Study of Caregiving: Costs to Work Caregivers: Double Jeopardy for Baby Boomers Caring For Their Parents*. Westport, CT: MetLife Mature Market Institute (estimating losses of \$303,880 on average in lost income and benefits over a caregiver's lifetime including about \$115,900 in wages, \$137,980 in Social Security benefits, and conservatively \$50,000 in pension benefits).

Vera Institute of Justice. (2011). *Guardianship Practice: A Six-Year Perspective*. Brooklyn, NY: Author. Retrieved May 27, 2014, from <http://www.vera.org/sites/default/files/resources/downloads/Guardianship-Practice-a-Six-Year-Perspective.pdf>. Note: This Vera project indicated that effective guardianship practices that aim to prevent unnecessary institutionalization and avoid costly crises can save Medicaid dollars. By contrast, abusive guardianships squander scarce court and family recourses and lead to expensive litigation and preventable acute care and crises. When it comes to elder abuse, guardianships can be either sword or shield – that is, when administered properly, they can help prolong independence and prevent elder abuse, but, wrongfully implemented can result in older people losing their assets or liberty.

U.S. Government Accountability Office. (2011). Stronger Federal Leadership Could Enhance the Response to Elder Abuse. GAO-11-208. Washington, DC: Author.

See Appendix D for list of statements.

Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging. (2011). Under the Radar: New York State Elder Abuse Prevalence Study. Self reported prevalence and documented case surveys [Final Report]. Retrieved May 27, 2014, from [http:// www.lifespan-roch.org/documents/UndertheRadar051211.pdf](http://www.lifespan-roch.org/documents/UndertheRadar051211.pdf).

Anetzberger, G. (2000). Caregiving: Primary Cause of Elder Abuse? *Generations*, 24(11), 46-51.

Jackson, S. L., & Hafemeister, T. L. (2011). Financial Abuse of Elderly People vs. Other Forms of Elder Abuse: Assessing Their Dynamics, Risk Factors, and Society's Response. Final Report Presented to the National Institute of Justice. Retrieved May 27, 2014, from <https://www.ncjrs.gov/pdffiles1/nij/grants/233613.pdf>

Griffith, H. R., Belue, K., Sicola, A., Krzywanski, S., Zamrini, E., Harrell, L., & Marson, D. C. (2003). Impaired financial abilities in mild cognitive impairment: A direct assessment approach. *Neurology* 60 (3), 449-457.

Connolly, M. T. (2012). High-Cost Blind Spot. *Public Policy and Aging Report*, 22(1), 8;
Gunther, J. (2011). The Utah Cost of Financial Exploitation. Salt Lake City, UT: Utah Division of Aging and Adult Services

Additional Elder Abuse Road Map References

1. Ingram EM. Expert panel recommendations on elder mistreatment using a public health framework. *Journal of Elder Abuse & Neglect*. 2003;15(2): 45-65.
2. Acierno R, Hernandez MA, Amstadter AB, et al. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*. Feb 2010;100(2): 292-297.
3. Choi NG, Mayer J. Elder abuse, neglect, and exploitation: Risk factors and prevention strategies. *Journal of Gerontological Social Work*. 2000; 33(2): 5-25.
4. Tataru T. Elder abuse in the United States: an issue paper. Washington, D.C.1990.
5. Teaster P, Dugar T, Mendiondo M, Abner E, Cecil K, Otto J. The Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older. Washington, D.C.2006.
6. Thomas C. The first national study of elder abuse and neglect: Contrast with results from other studies. *Journal of Elder Abuse & Neglect*. 2000;12(1): 1-14.

7. Lachs MS, Pillemer K. Current Concepts - Abuse and Neglect of Elderly Persons. *New England Journal of Medicine*; 332(7): 437-443.
8. Bonnie R, Wallace R, eds. *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging*. Washington, D.C.: The National Academies Press.
9. Wolf RS. Elder abuse and neglect: Causes and consequences. *Journal of Geriatric Psychiatry*. 30(1): 153-174.
10. Wolf R, Daichman L, Bennett G. Abuse of the elderly. In: Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R, eds. *World Report on Violence and Health*. Vol 123-146. Geneva: World Health Organization; 2002.
11. Anetzberger G. *The Clinical Management of Elder Abuse*. . New York.: Hawthorne Press; 2004.
12. American Medical Association white paper on elderly health. Report of the Council on Scientific Affairs. *Archives of Internal Medicine*. 1990;150:2459–2472.
13. Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson ME. The mortality of elder mistreatment. *Jama-Journal of the American Medical Association*. 1998; 280(5): 428-43
14. Lindbloom EJ, Brandt J, Hough LD, Meadows SE. Elder mistreatment in the nursing home: A systematic review. *Journal of the American Medical Directors Association*. Nov 2007; 8(9): 610-616.
15. Dong X, Fulmer T, Simon M, et al. Report Of Elder Self-Neglect And Mortality In A Community-Dwelling Population. *Journal Of Investigative Medicine*. Mar 2009 2009; 57(3): 558-559.
16. Lachs MS, Williams CS, Obrien S, et al. ED use by older victims of family violence. *Annals of Emergency Medicine*. 1997; 30(4): 448-454.
17. Baker MW, LaCroix AZ, Wu CY, Cochrane BB, Wallace R, Woods NF. Mortality Risk Associated with Physical and Verbal Abuse in Women Aged 50 to 79. *Journal of the American Geriatrics Society*. Oct 2009; 57(10): 1799-1809.
18. Dong XQ, Simon M, de Leon CM, et al. Elder Self-neglect and Abuse and Mortality Risk in a Community-Dwelling Population. *Jama-Journal of the American Medical Association*. Aug 2009; 302(5): 517-526.
19. Dong X, Simon MA. Elder abuse as a risk factor for hospitalization in older persons. *JAMA Intern Med*. May 2013; 173(10): 911-917.
20. Comijs HC, Penninx B, Knipscheer KPM, van Tilburg W. Psychological distress in victims of elder mistreatment: The effects of social support and coping. *Journals of Gerontology Series B-Psychological Sciences and Social Sciences*. Jul 1999; 54(4): P240-P245.
21. K P, D P. Psychological effects of elder abuse: a research note. *Journal of Elder Abuse and Neglect*. 1989; 1: 65–74.
22. Dyer CB, Pavlik VN, Murphy KP, Hyman DJ. The high prevalence of depression and dementia in elder abuse or neglect. *Journal of the American Geriatrics Society*. Feb 2000; 48(2): 205-208.
23. Begle AM, Strachan M, Cisler JM, Amstadter AB, Hernandez M, Acierno R. Elder mistreatment and emotional symptoms among older adults in a largely rural population: the South Carolina elder mistreatment study. *J Interpers Violence*. Jul 2011; 26(11): 2321-2332.

24. Cisler JM, Begle AM, Amstadter AB, Acierno R. Mistreatment and self-reported emotional symptoms: results from the National Elder Mistreatment Study. *J Elder Abuse Negl.* Jul 2012; 24(3): 216-230.
25. Fulmer T, Rodgers RF, Pelger A. Verbal mistreatment of the elderly. *J Elder Abuse Negl.* 2014; 26(4): 351-364.
26. Dong X, Chen R, Chang ES, Simon M. Elder abuse and psychological well-being: A systematic review and implications for research and policy - A mini review. *Gerontology.* 2013; 59(2): 132-142.
27. Spencer C. Exploring the Social and Economic Costs of Abuse in Later Life. . Vancouver, B.C.: University, Vancouver, B.C. for Health Canada, Family Violence Prevention Unit.
28. Dong XQ. Medical implications of elder abuse and neglect. *Clinics in Geriatric Medicine.* May 2005;21(2):293-313.
29. Mouton CP, Rodabough RJ, Rovi SLD, et al. Prevalence and 3-year incidence of abuse among postmenopausal women. *American Journal of Public Health.* Apr 2004; 94(4): 605-612.
30. MetLife Mature Market Institute, The National Committee for the Prevention of Elder Abuse, The Center for Gerontology at Virginia Polytechnic Institute and State University. *Broken Trust: Elders, Family & Finances.* Westport, CT2009.
31. MetLife Mature Market Institute. *The Metlife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation Against America's Elders.* Metlife Mature Market Institute/National Committee for Prevention of Elder Abuse/ Virginia Polytechnic Institute and State University, Metlife Mature Market Institute Westport, CT; 2011.
32. Acierno R. Elder Mistreatment: Epidemiological Assessment Methodology. In: Bonnie R, Wallace R, eds. *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging.* Washington, D.C.: The National Academies Press.; 2003: 261-302
33. Daly JM, Jogerst G. Statute definitions of elder abuse. *Journal of Elder Abuse & Neglect.* 2001; 13(4): 39-57.
34. Jogerst GJ, Daly JM, Brinig MF, Dawson JD, Schmuck GA, Ingram JG. Domestic elder abuse and the law. *American Journal of Public Health.* Dec 2003; 93(12): 2131-2136.
35. Laumann EO, Leitsch SA, Waite LJ. Elder mistreatment in the United States: Prevalence estimates from a nationally representative study. *Journals of Gerontology Series B- Psychological Sciences and Social Sciences.* Jul 2008; 63(4): S248-S254.
36. Holder, Y, Peden, M, Krug, G E, Lund, J, Gururaj, G and Kobusingye, O. 2001. *Injury Surveillance Guidelines,* Geneva, Switzerland: World Health Organization.
37. National Conference of Commissioners on Uniform State Laws. *Uniform Guardianship and Protective Proceedings Act (1997).* http://www.uniformlaws.org/shared/docs/guardianship%20and%20protective%20proceedings/ugppa_final_97.pdf
38. The American Heritage® Stedman's Medical Dictionary Copyright © 2002, 2001, 1995 by Houghton Mifflin Company. Published by Houghton Mifflin Company.

Financial Abuse References

World Health Organization (2002) *Missing Voices. Views of older people on elder abuse,* WHO:

Geneva

Lowndes, G., Darzins, P., Wainer, J., Owada, K. & T. Mihaljic (2009) Financial abuse of elders: a review of the evidence, Protecting Elders' Assets Study, Monash University: Melbourne

Human Rights Commission (2014) Your Rights in Retirement, Accessed 10/02/2014 <https://www.humanrights.gov.au/publications/your-rights-retirement/5-your-right-be-free-financial-abuse>

Kyle, L. (2012) Assets for Care: A guide for lawyers to assist older clients at risk of financial abuse, Seniors Rights Victoria: Melbourne

Brown, H. (2003) What is financial abuse?, The Journal of Adult Protection, 5(2):3-10

Lowndes, G., Darzins, P., Wainer, J., Owada, K. & T. Mihaljic (2009) Financial abuse of elders: a review of the evidence, Protecting Elders' Assets Study, Monash University: Melbourne

Alzheimer's Society (2011) Short Changed: Protecting people with dementia from financial abuse

O'Neill, N. & C. Peisah (2011) Capacity and the Law, Sydney University Press: Sydney

Lowndes, G., Darzins, P., Wainer, J., Owada, K. & T. Mihaljic (2009) Financial abuse of elders: a review of the evidence, Protecting Elders' Assets Study, Monash University: Melbourne

Kyle L. (2012) Assets for Care: A guide for lawyers to assist older clients at risk of financial abuse, Seniors Rights Victoria: Melbourne

NSW Government (2014) Planning Ahead Tools, Accessed 02/05/2014 <http://www.planningaheadtools.com.au/>

Davey, J.A. & J. McKendry (2011) Financial abuse of older people in New Zealand – a working paper, Institute of Policy Studies, Victoria University of Wellington Crosby, G., Clarke, A.,

Hayes, R., Jones, K. & N. Lievesley (2007)

Data Elements References

(1) Elder abuse prevalence in community settings: a systematic review and meta-analysis. Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Lancet Glob Health. 2017 Feb;5(2):e147-e156. <https://www.ncbi.nlm.nih.gov/pubmed/28104184>

(2) The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. Yon Y, Ramiro-Gonzalez M, Mikton C, Huber M, Sethi D. *European Journal of Public Health* 2018.

<https://www.ncbi.nlm.nih.gov/pubmed/29878101>

(3) The mortality of elder mistreatment.

Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson ME. *JAMA*. 1998 Aug 5;280(5):428-32.

<https://www.ncbi.nlm.nih.gov/pubmed/9701077>

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

Forum on Global Violence Prevention; Board on Global Health; Institute of Medicine; National Research Council. *Elder Abuse and Its Prevention: Workshop Summary*. Washington (DC): National Academies Press (US); 2014 Mar 18. II.6, ELDER ABUSE AND ITS PREVENTION: SCREENING AND DETECTION. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK208569/>