

# Elder Abuse Prevention

*Emerging  
Trends  
and  
Promising Strategies*



Lisa Nerenberg

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and Promising Strategies*

LISA NERENBERG, MSW, MPH

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# Author Biography

Lisa Nerenberg, MSW, MPH is a consultant in elder abuse prevention. Previously, she directed the San Francisco Consortium for Elder Abuse Prevention at the Institute on Aging, which was one of the first elder abuse prevention programs in the country. Under her leadership, the Consortium piloted some of the country's first abuse prevention services and interventions, including a multidisciplinary team, a counseling program and support group for victims, and culturally specific outreach. She has provided training and technical assistance to local, state, and national organizations; developed comprehensive training curricula; delivered keynote addresses, moderated panels, and made presentations at hundreds of professional forums in the United States and Canada. Ms. Nerenberg has testified before Congressional committees and served on governmental advisory committees and panels. She has authored dozens of articles, chapters, and publications on such far-ranging topics as coalition building, the role of culture and gender in elder abuse, financial abuse and the special needs of financial crime victims, daily money management, and the role of the civil and criminal justice systems in elder abuse prevention. A special area of interest is cross-disciplinary exchange among professionals in the fields of aging, criminal justice, victim-witness assistance, health and mental health, domestic violence, and adult protective services. Her Web site (<http://www.lisanerenberg.com/>) and blog (<http://preventelderabuse.blogspot.com>) address cutting-edge issues in the field today.

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# Preface

If, as some suggest, the moral test of a society is how it treats its elders, the shocking accounts of elder abuse that are increasingly hitting the headlines cast us in very grim light. Almost daily, we hear about frail, abandoned elders languishing in filth; adult children plundering their parents' estates; and predators preying upon the sick, disabled, and lonesome.

But societies are also defined by how they respond to problems, and in the quarter-century since elder abuse first emerged into the public's consciousness, professionals, advocates, and concerned citizens have demonstrated remarkable ingenuity and determination. They have scoured the literature from far-ranging disciplines in search of explanations and strategies, forged alliances with unlikely partners, and grappled with such slippery questions as when to intervene in the lives of elders who do not want help.

This book describes what has been accomplished and what remains to be done to stop abuse, treat its effects, and ensure justice. It further addresses the broader need to fortify our long-term care, protective service, and legal systems to meet the new and imminent demands of a burgeoning elderly population. In short, it is about making our communities safer places to grow old.

In writing the book, I have drawn from the published literature, from observations shared by colleagues, and, to a great extent, from my own experiences over the last twenty-four years. For most of that time, I directed the San Francisco Consortium for Elder Abuse Prevention, one of the first programs to address elder abuse. During those years, and in the seven years since starting a private practice, I have worked with hundreds of agencies, state and local coalitions, planning councils, and multidisciplinary teams across the United States and Canada. No two are quite alike, yet neither are they very different.

San Francisco's response to elder abuse began in 1981, when the House Select Committee on Aging held one of its groundbreaking hearings here, and several local professionals were invited to testify. The event sparked interest and prompted the local Coalition of Agencies Serving the Elderly (CASE) to assign a task force to explore the issue further.

What happened next reads like a textbook case study in community organizing. The task force developed a questionnaire survey for local agencies, asking them about abuse victims they had served during the past year, their abusers, the circumstances, and what the agencies had done. Although the survey only generated 146 cases, it was the largest study of its kind at the time and yielded valuable insight into victims' service needs. More importantly, it pointed out that no single agency was equipped to meet all those needs, which ranged from medical treatment to legal assistance. The task force called for agencies to work together and designed a model, which became the blueprint for the San Francisco Consortium for Elder Abuse Prevention. Key features were a steering committee, a coordinating agency, advocacy and training committees, and a multidisciplinary case review team. They charged Mount Zion Hospital with coordinating the new program.

That was in 1983. I had just moved to San Francisco from Minnesota, where I had recently finished my graduate coursework in public health and social work. I was looking for an unpaid internship, and someone referred me to Mount Zion. Because the hospital had not received any funding to launch the new elder abuse program, I was a perfect candidate for the job. Susan Garbuio, one of the driving forces behind the task force and an innovator in aging services, "hired" me.

One of my first responsibilities was to organize and provide staff support to the Consortium's multidisciplinary team, which met monthly to review complex cases. Because I had never worked with elders and had not had any courses on aging in grad school, it was not long before I was in over my head. Team members rattled off terms like IADLs, MSSP, MMSE, 5150s, APS, TIAs, and ADHCs; and a police officer grilled a social worker about whether a perpetrator had struck her client with an open hand or closed fist. When someone reported that a client knew who the last president was but could not count backward by sevens, I felt sure I had stumbled through the looking glass.

I appealed to Susan for help. She explained what she could and directed me to others on the team to fill in the blanks. After many calls, I came to the realization that there was no single point during any meeting when everyone around the table understood what was going on. From then on, I took it upon myself to interrupt and ask for explanations. In doing so, I discovered that embedded in all those cryptic codes and riddles were the secrets to helping victims. I started picking up the jargon and

learned that the difference between striking someone with a flat hand and closed fist might determine whether criminal charges applied and whether the victim's cooperation was needed to move forward. The inability to count backward or remember presidents suggested impairments that heightened vulnerability and dictated what interventions were needed. When I noticed others around the table staring at me, I knew it was my cue to interrupt on their behalf.

There is nothing quite as contagious as the creative energy that flows when service providers swap ideas and information to help clients. But our discussions were not limited to clients; team members voiced their frustrations, identified unmet needs, and prodded each other to tackle new problems and cases. We shared successes, commiserated on failures, and railed in outrage when systems failed. Team members tried out new approaches. Our local legal assistance to the elderly program became one of the first in the country to use domestic violence restraining orders to protect elderly victims from abusive offspring as well as partners. Staff of a daily money management program explained how clients were cheated and scammed and instructed us in how to reduce their risk. Getting to know police, nurses, lawyers, doctors, mental health professionals, and prosecutors was personally and professionally enriching, and these early experiences instilled in me a fascination with interdisciplinary exchange and program development.

Not long after the Consortium was up and running, we started getting requests from other communities and coalitions for help, and, in 1985, received the first of several grants from the Administration on Aging, Department of Health and Human Services, to provide training, consultation, and technical assistance. Some of the programs I worked with, like our Consortium, were inspired by government initiatives, whereas others were mandated, launched in response to local tragedies, or started because someone got a grant. Regardless of their origins, the programs were remarkably similar in several respects. All recognized that preventing elder abuse required a multidisciplinary response. The agencies and disciplines represented at the table were essentially the same regardless of whether the table was in Illinois or New York. So too were the challenges they faced, the jargon members used, and the services their clients needed.

Multidisciplinary exchange and cooperation are not always easy. Professional outlooks and opinions reflect deeply rooted commitments, values, and ideologies. When professionals from diverse backgrounds disagree on how to handle cases or address systemic problems, sparks may fly or fingers point. But these exchanges are a necessary part of ensuring that clients benefit from the full range of available options. The goal of multidisciplinary exchange is not to reach consensus but rather to ensure that all points of

view are considered and to provide a system of checks and balances. Eventually, as service providers come to understand the restrictions and limitations their colleagues operate under, these exchanges become more collegial.

As the field developed, we drew from an increasingly wide array of disciplines and service delivery models. The perspectives, strategies, and resources that other disciplines contribute have enriched our field, but growth has not come without conflict. Ideological differences and competition for scarce resources have led to turfism and “clashing paradigms.” “New and improved” models have been advanced and credited with trumping those that came before.

But elder abuse defies one-size-fits-all solutions. I believe that the best way to overcome competition and conflict is to help diverse groups understand one another. That is the goal of this book. It is intended to help readers better understand and appreciate the rich, if sometimes discordant, patchwork of theory and practice that defines our field. It is for those who work in the fields of aging, Adult Protective Services (APS), dementia care, mental health, legal aid, victim-witness assistance, domestic violence, law enforcement, and others. It is for both newcomers to the field and veterans. It is intended to augment these workers’ repertoires of skills and lead to greater interdisciplinary collaboration and coordination. It is also for advocates, program developers, and concerned citizens, who want to improve their agencies,’ communities,’ tribes,’ or states’ responses to the problem.

For many years, the San Francisco Consortium had a committee called WE ARE FAMILY, which focused on the special needs of African American elders. The group had a tradition that I found very moving. Outreach events began with a *libation*, a prayer used in traditional African life to keep families linked to their legacies and honor those who came before. Members of the audience were invited to shout out the names of their ancestors, elders, and mentors. Following in that tradition, I would like to invoke the names of a few individuals who influenced and inspired me. Rosalie Wolf, a friend and mentor, embodied the spirit of collaboration and inclusiveness. She also believed that research, practice, and policy must be intertwined, and, to that end, she conducted numerous practice-focused studies and founded the *Journal of Elder Abuse & Neglect*, the National Committee for the Prevention of Elder Abuse, and the International Network for the Prevention of Elder Abuse. Jack McKay, also a friend and mentor, was a founding member of the San Francisco Consortium and a pioneer in the field of aging and daily money management. A strong believer in collaborative planning, he urged us to envision the future, even during times of retrenchment, when the possibility of growth or change seemed remote. “Know what you want,” he would often say, “and you’ll be surprised by what you can achieve.”

# Acknowledgments

I am indebted to the many friends and colleagues who have made my work both professionally and personally enriching. Special thanks to Mary Joy Quinn, who encouraged and inspired me to write this book, and to Eileen Goldman, for her careful read, insights, and feedback. I would also like to thank the many others who shared their ideas, case examples, and knowledge, including Melissa Anderson, Mary Counihan, Debbie Deem, Arlene Groh, Casey Gwinn, Judy Hitchcock, Diana Koin, Shawna Reeves Nourzaie, Nancy Rasch, Mary Twomey, members of the San Francisco Consortium, and colleagues around the world.

## CHAPTER ONE

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# Eight Trends Shaping Practice

### INTRODUCTION

As is the case with any field, elder abuse prevention has been shaped and defined by a confluence of events, discoveries, and happenstance. Most histories have highlighted milestones in the development of public policy and research. But there are also overarching pressures, forces, and trends that have defined us, shaped the service delivery network, and propelled us in new directions. Some have emerged from within the field, whereas others have been imposed from without.

In this chapter, I have identified eight trends that I believe have particular significance for practice in the field today. Some are related and interconnected, whereas others are in opposition. There are undoubtedly other forces at work as well, but I believe these provide a good starting point for discussing where we have been, where we are now, and where we are going:

1. Increasingly frail elders living at home
2. Shifting paradigms: From protection to empowerment
3. Heightened understanding of victims
4. The circle widens: The burgeoning abuse prevention network
5. The changing role of APS
6. The “criminalization” of elder abuse
7. Focus on forensics
8. Going global: International initiatives to prevent elder abuse

## 1. INCREASINGLY FRAIL ELDERS LIVING AT HOME

When I started working for the San Francisco Consortium in 1983, it was an exciting time to be in the field of aging. Mount Zion Hospital, where I worked, offered home care, adult day health care, and case management. It was just wrapping up a research and demonstration project that compared the costs and benefits of nursing homes to those of community-based care for frail elders. Within the next few years, half a dozen new programs were launched.

What these programs had in common was the goal of enabling frail elders to live at home. The home-care program brought skilled nursing care into clients' homes, and the adult day health program brought those who would otherwise be relegated to nursing homes to the center, where professionals provided skilled nursing, medical monitoring, and rehabilitative services. Not surprisingly, the research project showed that it was cheaper to keep frail elders at home, up to a certain point at least, when clients' needs became so great that nursing home care made more sense (Miller, Clark, & Clark, 1998). Clients' ability to remain at home depended on case managers who carefully assessed their needs, crafted complicated service plans, arranged for services, and monitored how things were going. Mount Zion was not unique in its preoccupation with keeping clients at home. Agencies around the country were doing the same.

What was remarkable to me was the precariousness of many elderly clients' situations. It was not unusual for the case managers to arrange for attendants to come to clients' homes for an hour or two in the morning to help them get up, dressed, and ready to be picked up and taken to the adult day health care center. There, they would get their only hot meal of the day; have their health status and medications checked; and receive occupational, physical, or speech therapy. Evenings, other attendants might come to help them get ready for bed. A single event like an attendant not showing up for work on time could have a ripple effect, resulting in clients missing meals, treatment, therapy, or medical appointments. It was often a balancing act for their case managers. Two decades earlier, concerns about incapacitated elders and adults with disabilities living alone in the community with nobody to help them had prompted amendments to the Social Security Act, which created an "adult protective services" (APS) safety net. The purpose of APS was to provide legal, social, and support services aimed at preventing institutionalization, abuse, and neglect (Anetzberger, 2005). It was not a perfect system. When I started, there were only two dedicated APS workers in San Francisco and a few workers in other county programs who carried some additional APS cases. Other communities were similarly understaffed.

In light of the situation, it was not surprising that the first early congressional hearings on elder abuse and neglect, which began in 1978, focused on frail elders who depended on others for care. What is often cited as the inaugural step in elder abuse public policy in the United States was testimony before the House of Representatives during a hearing that was attempting to identify the overlooked or ignored aspects of family violence (U.S. House of Representatives, 1978, p. 159). Over the next twenty-five years, many more congressional hearings were held, reports issued, and legislation proposed (Wolf, 2003).

By the late 1980s, it seemed as though we were keeping everyone at home who could reasonably be kept there safely. But later developments suggested otherwise. Foremost among these was the “Olmstead Decision.”

In 1995, the Atlanta Legal Aid Society filed *Olmstead v. L. C.* (1999) on behalf of two women who were patients in a state psychiatric hospital. After those treating the women agreed that they could be discharged into community programs, the women were not released until many months later. The court found that the state’s failure to release them when it was appropriate to do so was a violation of their civil rights. In essence, the case established community-based care, with reasonable accommodation, as a right protected under the Americans with Disabilities Act. An executive order followed, challenging states to develop more opportunities for people with disabilities to live at home through reforms in health care, transportation, housing, education, and other social supports.

The decision had sweeping impact. States across the country created Olmstead-related task forces to develop plans for making sure that people with disabilities were living in the least restrictive settings possible (Fox-Grage, Coleman, & Folkemer, 2004). The decision also fueled the “consumer-directed care,” or “consumer choice,” movement, which was aimed at empowering health care “consumers” to exercise greater choice and direct their own care. The Centers for Medicare & Medicaid Services (CMS) awarded millions of dollars in grants for consumer choice programs and the Robert Wood Johnson Foundation has provided additional major funding.

Although consumer choice programs vary, a primary goal is to prevent unnecessary institutionalization. Some programs even assess nursing home patients to determine if they can be transferred into community-based settings. To promote the goal of greater consumer choice, beneficiaries of publicly funded services have been provided with more opportunities to direct their own care. Some, for example, receive vouchers instead of services; the vouchers can be used for home repair or modifications or to purchase assistive devices. Some programs permit consumers to select

and manage their own caregivers instead of having licensed home-care professionals do so for them. They may have the option of hiring friends, neighbors, and family members.

Although these developments clearly suggest the need for reinforcing the safety net, state Olmstead plans do not typically address the need for additional protective services. Perhaps more disturbing is the fact that there has been little interaction between the consumer choice and APS or elder abuse prevention networks, and in some instances the two have operated in opposition to each other. For example, many in the field of elder abuse prevention have called for action to reduce the heightened risk of abuse and neglect by independent home-care providers, while consumer choice advocates have argued that consumer-direction programs do not place older adults at heightened risk (Matthias & Benjamin, 2003; Squillace & Firman, 2004).

## **2. SHIFTING PARADIGMS: FROM PROTECTION TO EMPOWERMENT**

The elder abuse prevention field's early focus on protecting frail elders and the patterning of APS on CPS led to frequent charges of ageism and paternalism (Kleinschmidt, 1997; Macolini, 1995). APS professionals have consequently taken pains to distinguish themselves from their colleagues in CPS by emphasizing their commitment to client autonomy, self-determination, and personal freedom (see Chapter 3). They, and others who work with abused and vulnerable elders, have adopted new services and approaches that emphasize empowerment and extended their focus to include elders who are not frail and dependent. In doing so, they have drawn from the fields of domestic violence and victims' rights, adapting techniques like consciousness-raising, options counseling, support groups, safety planning, and legal advocacy (see Chapter 3 for descriptions of these models and Chapter 5 for descriptions of specific services).

This trend is further reflected in the renaming and reframing of public policy related to elder abuse. The labeling of the first comprehensive federal legislation on elder abuse the "Elder Justice Act," for example, emphasizes both societal and personal empowerment for elders. From a societal perspective, vulnerable and abused elders are entitled to parity with respect to services and access to the justice systems. From an individual perspective, elders, including those with diminished capacity, have the right to live free of abuse, neglect, and exploitation, while maintaining their autonomy.

### 3. HEIGHTENED UNDERSTANDING OF VICTIMS

One of the conundrums of working with abused and vulnerable elders is that many refuse help. Their reticence stems from many factors, including fear of retribution or making matters worse, shame, loyalty to abusers, social and cultural prohibitions, and distrust of the protective service and legal systems.

Professionals in the field responded by writing articles, giving speeches, and organizing training events that focused on “resistant and reluctant” clients. Through these activities, we reminded others and ourselves that our charge was to protect clients’ civil liberties as well as their safety. Still, many were uncomfortable with our collective failure to engage clients in the helping process. This frustration may well account for the enthusiasm we have seen for each new discovery or insight that helps explain why clients do what they do and, perhaps more importantly, why they often don’t do what we think they should.

There have been several “breakthroughs” that enriched our understanding of victimization, the help-seeking process, and how we can help. The infusion of domestic violence theory, research, and practice into our field, which began in the early 1990s, alerted us to the power and control dynamics operating in some abusive relationships and to the social, economic, and cultural obstacles many victims face. The domestic violence model, which is described in Chapter 3, also acknowledges that violence within relationships does not occur randomly but follows patterns or cycles, which affect victims’ receptivity to help and account for the fact that many refuse or change their minds many times before taking decisive action to stop the violence. Understanding that victims march to the beat of their own drums, and that accepting help is a process rather than a single decision, suggested the need for service providers to reevaluate their thinking about how they could help.

Other fields have also shed light on victims, abusers, and the relationships between them and given us new tools. The field of victimology has taught us how to work with people who suffer from post-traumatic stress disorder (PTSD), diminished self-esteem, and isolation; and the field of family caregiver support has helped us understand the dynamics in caregiving relationships and how to intervene when conflicts occur. Neutralization theory, which emerged from the field of criminology, explains how abusers rationalize their behavior and how victims may reinforce these rationalizations. These models and the guidance they offer are described in greater detail in Chapter 3.

Heightened understanding about cognitive functioning and its relationship to decision-making capacity has also helped us better understand and serve elderly victims. Diminished capacity not only increases

vulnerability to certain forms of abuse but also may impair elders' ability to understand what has happened, take action to stop abuse, and plan for the future. It further determines what services and interventions are available to them. Whereas capacity was once viewed as a "you've got it or you don't" proposition, we now understand that specific mental skills like memory, the ability to calculate, and orientation to time and place are needed for specific tasks and that some tasks require greater skill than others. We have learned more about how impairments in these areas affect our everyday lives. More recently, we have achieved a clearer understanding of "executive functions," which include complex, subtle mental abilities such as being able to plan for the future or the mental flexibility to shift from one mental task to another. These complex processes further affect elders' ability to act in their own self-interest, protect themselves, or seek or accept help from others. Perhaps nowhere is the research on the psychology of victimization more promising than in the areas of financial abuse and consumer fraud. In recent years, researchers have identified increasingly subtle and complex cognitive deficits, psychological factors, and personality traits that explain why victims fail to recognize seemingly obvious tactics or take steps to protect themselves or seek help. For example, a recent study suggests a link between memory deficit and vulnerability to scams (Jacoby, Bishara, Hessels, & Toth, 2005).

The "discovery" of undue influence as a significant factor in elder abuse further revolutionized thinking, a breakthrough I credit in great part to San Francisco prosecutor Dennis Morris, who came to a meeting of San Francisco's multidisciplinary team over a decade ago and asked the group if anyone knew of an expert in "brainwashing." He was working on a case involving a wealthy woman in her nineties who had recently been spirited off to Nevada for a quickie wedding to a much younger man. The man had moved into the older woman's home and was in the process of appropriating her assets when a relative got suspicious and initiated an investigation. Despite the justice of the peace's assurances that the elderly bride knew what she was doing, Morris was not convinced. Some members of our team found his request a bit odd, as nobody was talking about undue influence in relation to elder abuse back then, but someone suggested he speak to Margaret Singer, a psychologist and expert on cults, brainwashing, and deprogramming prisoners of war.

Morris contacted Singer, who studied the case and subsequently testified before a grand jury. She described the classic forms of social persuasion that the younger man and an accomplice had used to get the older woman to "willingly" allow them to take over her home and property (Nerenberg, 1996). According to Singer, undue influence has little to do with intelligence or cognition, and anyone can be unduly influenced if

“artful manipulators,” as she called them, are artful enough. To understand the older woman’s apparent compliance, Singer explained, examiners needed to look beyond the older woman’s mental status at the time she took her vows and consider the psychological manipulations that had been exerted on her prior to the event. This process included isolating her and fostering dependency. They also instilled a “siege mentality,” convincing her that the voices she heard coming from outside her house were those of drug dealers and that it was too dangerous for her to go out or let others in. In fact, she lived in one of San Francisco’s poshest neighborhoods, and the voices belonged to security guards at a nearby consulate. The perpetrator was convicted in what became a landmark case, and Singer went on to write and lecture extensively about undue influence in elder abuse. Many others followed, enriching our understanding of undue influence.

#### **4. THE CIRCLE WIDENS: THE BURGEONING ABUSE PREVENTION NETWORK**

The multidisciplinary nature of elder abuse prevention has long been recognized and is reflected in our research, policy, and practice. State reporting laws enlist the help of professionals from diverse fields to identify cases, multidisciplinary teams have become a hallmark in elder abuse prevention, and diverse groups have received training in abuse detection and response.

The range of disciplines that are acknowledged to have a role in abuse prevention has continually been stretched. Year after year, states have amended their reporting laws to extend coverage to include such far-ranging groups as clergy, employees of financial institutions, and animal care and control workers.

Multidisciplinary teams, which historically included APS workers, mental health professionals, case managers, medical and health care providers, lawyers, police, and many others, have broadened their memberships to include ethicists, judges, clergy, bankers, animal rights advocates, and many more. Beginning in the mid-1990s, new “hybrid” teams began to appear to address specific forms of abuse, bringing even greater diversity to teams (Teaster & Nerenberg, 2003). (See Chapter 6 for more on multidisciplinary teams.) The first Financial Abuse Specialist Team (FAST), started in Los Angeles, brought in stockbrokers, private fiduciaries, bank personnel, experts in insurance and real estate, and many others. Because certain types of financial abuse fall within the jurisdiction of federal law enforcement and regulatory agencies, representatives from U.S. attorneys’ offices,

the Federal Bureau of Investigation, the Federal Trade Commission, the Secret Service, the Social Security Administration, the Postal Service, and others have joined.

Another new form of hybrid team is the death, or fatality, review team. These teams—which were formed to achieve a clearer understanding of elder deaths, help prosecutors build cases, distinguish “natural” deaths from accidents or homicides, and explore systemic problems or professional conduct that led to deaths—may include coroners, medical examiners, funeral home directors, morticians, hospice care staff, homicide investigators, and others. Medically focused teams, formed to offer increasingly specialized medical assessments, chart reviews, and consultation, may include members with expertise in such areas as geriatrics, forensics, psychiatry, emergency medicine, and others.

The elastic boundaries of the field are further evidenced by the wide range of professionals who have received training in abuse detection and response. Groups for whom training curricula and programs have been developed in recent years include dentists, victim advocates, emergency medical services personnel, bank employees, judges, prosecutors, securities specialists, librarians, sexual assault teams, and many others.

## 5. THE CHANGING ROLE OF APS

When APS programs first began, workers’ primary role was to assess vulnerable adults’ need for social and protective services. Later, when states passed reporting laws that made APS responsible for receiving and investigating abuse reports, workers assumed new roles. Whereas APS workers had traditionally focused on clients’ social service needs, regardless of what had created those needs, they were increasingly called upon to classify abuse and neglect, substantiate it, and identify perpetrators; and they started working more closely with law enforcement. Over time, as more cases were handled through the criminal and civil justice systems, APS workers began to play an even greater role in collecting evidence, substantiating claims, and testifying in legal proceedings. Some APS units now operate abuse registries, which contain information about offenders that may be used to build legal cases or alert prospective employers.

Even in cases that do not involve perpetrators—when a client’s need for help stems from health or mental health problems, lack of resources, or lack of information about or access to resources—workers may feel compelled to categorize situations as “self-abuse” or “self-neglect,” suggesting that it is the client who is responsible for his or her circumstances. These heightened pressures to “name and blame” (to label conduct as abuse and identify who is responsible) have created additional challenges.

Often it is not apparent whether neglect is self-imposed or whether others are responsible. Distinguishing neglect from self-neglect may also involve determining whether a client has sufficient capacity to consent to or refuse help, whether the incapacity is permanent, and whether others have a “duty” or responsibility to provide care. While psychologists and legal experts still struggle with these issues, APS workers are forced to make informal judgments about them on a daily basis.

Pressures to name and blame can also have a negative impact on workers’ relationships with their clients or even create conflicts of interest. When clients do not want to see their abusers punished, APS workers may find their roles as advocates and investigators incompatible. Workers’ role as investigators may alienate clients or destroy their trust in workers. The recent emphasis on identifying abuse and abusers may also distort perceptions about APS. Workers are increasingly viewed by some as quasi law enforcers rather than as service providers whose primary goal is to provide support and services.

The “stakes” for making misjudgments and mistakes with respect to clients’ level of risk, to who is responsible, and to appropriate interventions have become much greater. In the early days of APS, when workers simply determined whether someone needed services, they could risk erring on the side of caution. If they wrongly determined that someone was at risk, it simply resulted in that person receiving social and support services he or she was not entitled to. Today, however, when workers conclude that abuse has occurred, it can have extremely negative repercussions for alleged abusers. It may disqualify them from employment or even prompt criminal investigations or civil proceedings. Wrong decisions can expose agencies and individual workers to lawsuits or disciplinary action. To help them function in this new environment, workers are being provided with increasingly complex and sophisticated instruction and instruments, which are described in Chapter 3 (Moskowitz, 1998; Otto, 2000; Roby & Sullivan, 2001).

## **6. THE “CRIMINALIZATION” OF ELDER ABUSE**

One of the most dramatic changes in recent years is the increasing number of elder abuse cases that are being prosecuted. This trend can be credited to the pioneering efforts of creative and tenacious police, prosecutors, and lawmakers who have introduced new techniques, procedures, and statutory innovations (American Prosecutors Research Institute, 2003). These include enhanced penalties for crimes involving elders; “evidence-based prosecution,” an approach designed to help prosecutors build cases even when victims are unavailable or unwilling to participate; and specialized

elder abuse units within police and prosecutors' offices. Law enforcement officials are increasingly being encouraged to consider domestic violence crimes, when applicable, when charging elder abuse cases.

Criminalizing abuse sends out a clear message to perpetrators that abuse is not tolerated by society; a message that not only is believed to have a deterrent effect but also may further serve to counter the rationalizations that abusers make to themselves and others. (See Chapter 3 under "Neutralization Theory.") It conveys to perpetrators that they must answer not only to victims but also to society, which will bring to bear the resources of the criminal justice system. Incarcerating perpetrators obviously protects victims and potential victims, at least temporarily, and provides supervision and leverage over perpetrators prior to, after, or in lieu of incarceration. Perpetrators can also be ordered to pay restitution to those they have harmed, serve their communities, or undergo treatment.

Along with these benefits, however, come new challenges. The criminal justice system is poorly equipped to handle certain types of elder abuse cases, such as domestic disturbances involving spouses with dementias. In jurisdictions that have mandatory arrest policies for domestic violence, law enforcement officials may feel compelled to make arrests in these cases. Additional problems associated with domestic violence laws are described in greater detail in Chapter 3.

There seems to be a perception among some that criminal justice approaches to elder abuse are in opposition to, or in conflict with, therapeutic or supportive approaches aimed at reinforcing caregiving networks, relieving stress on caregivers, and addressing the social, emotional, and financial needs of family units. This belief may stem from understandable fears that workers will confuse "caregiving issues" with domestic violence, leading to inappropriate responses or even using caregiver stress as an appropriate defense in criminal abuse cases. The 2002 Canadian video *What's Age Got to Do with It* offers a poignant account of what can happen when service providers miss the signs of lethal domestic violence by a caregiver.<sup>1</sup> Although these concerns are understandable, this either-or attitude toward criminal and therapeutic approaches fails to acknowledge the wide variations that characterize elder abuse. It further threatens to polarize the dementia care and criminal justice networks at a time when collaboration is sorely needed to devise effective, humane, and appropriate approaches.

## 7. FOCUS ON FORENSICS

The focus on holding perpetrators accountable has heightened the need to build legal cases against abusers and highlighted the problems inher-

ent in doing so. Because abuse typically occurs in private and victims are often unable or unwilling to tell outsiders what happened, proving abuse often involves “letting the evidence speak for itself,” supplemented by research and expert testimony.

But the evidence in elder abuse cases does not typically speak for itself. Because elders bruise more easily than young people, fall more often, and are more likely to have illnesses and conditions that mimic abuse and neglect, proving abuse often involves demonstrating that injuries were inflicted, not accidental; that neglect was willful, not benign; and that deaths were not “natural” (Dyer, Connolly, & McFeeley, 2003). These challenges have resulted in heightened attention to forensics, which is defined as the “application of science to law.” It uses scientific methods to analyze and interpret evidence to determine what happened, when it happened, and whether explanations and defenses are plausible. Medical forensics experts attempt to explain how, when, and why injuries occurred. They draw from forensics medical studies, which explore and compare the “mechanisms” and patterns of inflicted injuries and those of natural occurrence. Other types of forensic experts who may be needed in elder abuse cases include forensics accountants, forensic radiologists (Brogdon, 1998), forensic odontologists (Golden, 2004), forensic entomologists (Benecke, Josephi, & Zweihoff, 2004), forensic psychiatrists (Naimark, 2001), and many more.

Both the federal and state governments have responded to the need for forensics expertise. At the national level, the U.S. Department of Justice (DOJ), in October of 2000, hosted the National Symposium on Forensics Issues in Elder Abuse, a discussion between researchers, medical and forensics experts, and practitioners from the fields of health care, social services, and law enforcement. After reviewing the current state of the art and challenges involved in identifying and substantiating abuse and neglect, the group called for research to establish abuse “markers” (indicators that reliably predict abuse) and other evidence-based data to support findings of abuse, clearinghouses of forensics experts who are available to testify or consult in cases, and databases of documented findings that can be used by prosecutors (Dyer, Pavlik, Murphy, & Hyman, 2003).

Since then, the DOJ has continued to play a leadership role (McNamee & Murphy, 2006). It has supported several studies, including one on bruising at the University of California–Irvine (UCI) that provides baseline data on “natural” bruising that can serve as the basis for evaluating nonnatural bruising (Mosqueda, Burnight, & Liao, 2005). UCI is conducting another study of the rates of pressure ulcers in nursing homes, which will be used to help identify substandard care. Another DOJ-sponsored study examined coroners’ reports of elderly nursing home residents in Arkansas to identify abuse markers, and a third explores

markers by cross-referencing data on abuse taken from an APS databank in Texas with state medical examiners' reports.

States have also contributed. California supported the development of a forensics assessment tool, enacted legislation allowing elder fatality review teams to share information, and provided technical assistance and training to teams. Local communities and agencies have also gotten involved by organizing death review teams, launching forensics centers, and providing APS programs with access to forensics experts. These state and local initiatives are described in Chapters 6, 7, and 8.

## **8. GOING GLOBAL: INTERNATIONAL INITIATIVES TO PREVENT ELDER ABUSE**

Elder abuse was first recognized in Great Britain, the United States, and Canada; and for many years, most research, program development, and practice emerged from these countries. But in the late 1990s, researchers and service providers from around the world began to meet at international professional conferences to discuss abuse, and, in 1997, a small group launched the International Network for the Prevention of Elder Abuse (INPEA).

Several major developments followed. In 2002, the United Nations (UN) convened the Second World Assembly on Aging in Madrid, Spain. During the event, delegates adopted an International Plan of Action, which acknowledged elder abuse as a human rights and public health issue and included recommendations for addressing it (United Nations Economic and Social Council, 2002). Follow-up activities include the Worldwide Environmental Scan of Elder Abuse, which is being conducted by INPEA in partnership with three universities. Scanning is the identification of emerging issues, events, trends, situations, and potential pitfalls used for planning and decision making. The elder abuse scan is a computerized survey, posted on INPEA's Web site, that solicits information on public policy, services, educational resources, and training on elder abuse. In 2002, the UN's International Research and Training Institute for the Advancement of Women (INSTRAW) sponsored an electronic discussion forum, "Gender Aspects of Violence and Abuse of Older Persons," which drew participants from around the world and highlighted issues of abuse in developing countries (AgeingNet, 2002).

The World Health Organization (WHO) has also called for a world strategy to combat the problem. To learn more about what was needed, WHO collaborated with INPEA, HelpAge International (a global network of nongovernmental, nonprofit organizations, or NGOs), and representatives from academic institutions around the world, in conducting

focus groups of elders and primary health care workers<sup>2</sup> in Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon, and Sweden. The focus groups identified key themes, perceptions, beliefs, and attitudes, which are summarized in the report *Missing Voices: Views of Older Persons on Elder Abuse* (WHO/INPEA, 2002).

These initiatives have revealed that elder abuse is defined and perceived very differently around the world. For example, disrespect of elders is viewed as one of the most prevalent and painful forms of abuse. Focus group members in the WHO/INPEA study cited the abandonment of family members in health care facilities such as hospitals as a major problem, with some identifying it as the most frequent form of abuse. Hospital staff in Kenya estimated that between 15% and 30% of older patients end up abandoned in hospitals owing no doubt to the fact that elders or their families have to pay for health care services. Placing elder family members in nursing homes was considered by many respondents to be a form of elder abuse. In the developing countries, placement into long-term care was regarded as a last response for the very poorest people who had no family to care for them.

The “global perspective” on elder abuse attributes abuse and neglect to a variety of factors, many of which reflect underlying economic and social inequalities. The status of elderly women in society is a common theme. A report from the UN secretary-general to the World Assembly on Aging acknowledged the role of sexism and ageism in elder abuse (United Nations Economic and Social Council, 2002), citing “patrilineal inheritance laws and land rights” among the factors that contribute to older women’s vulnerability. Participants in the INSTRAW forum further pointed out the futility of addressing elder abuse while ignoring the broader context of institutionalized sexism and ageism that have led to such blatant abuses against women and girls as female feticide (the aborting of female fetuses) and *karo kari* (honor killings), which are still practiced in some developing countries despite efforts to eradicate them (AgeingNet, 2002).

Changing social roles are also blamed. The influx of women worldwide into the job market has reduced the availability of family caregivers, traditionally women, which is believed to result in emotional and physical neglect as well as verbal and physical abuse. The lack of social security systems, fair pensions, and legal protections with respect to inheritance laws also contributes. Worldwide, only 30% of elders are covered by pension plans, leaving many elders without income (United Nations Economic and Social Council, 2002). The situation is worse for women. In many African countries, for example, widows’ property is passed on to their elder sons or back to their husbands’ families. In other traditional societies, older widows are subject to abandonment and “property grabbing.”

Elders' lack of access to health care and social services is another common theme. A decrease in rates of communicable diseases in the developing world over the last few decades has increased the prevalence of long-term, disabling diseases and the need for long-term care. Lack of public funding for basic services puts financial pressure, stress, and burden on families. The poorest members of society are the worst off, and many older adults (especially older women) fall into this category.

Health care professionals are viewed as part of the problem. WHO/INPEA focus group members claimed that health care workers were inadequately trained in aging and older people's problems and did not have enough time to listen to elderly patients. Many, however, view health care providers as victims too, citing poor working conditions and low pay as contributing to abuse. Nurses at one hospital confessed that they "do not look kindly upon older patients who have trouble settling their bills" because they realize that their working conditions will only improve with larger revenues from patients. Others agreed that there was a link between the treatment of workers and the treatment of patients. Many also felt that there was prejudice against geriatrics as a field and that other health care professionals and administrators viewed those who work with elders as less qualified, which accounts for low salaries in this specialty.

Other factors contributing to abuse and neglect that have been identified by global forums include economic crises, the influence of the media in promoting ageist attitudes and negative stereotypes, and westernization. As a result of economic downturns in Argentina and Brazil, for example, adult children are moving back into their parents' homes, sometimes forcing them to move out. In sub-Saharan African countries, including Mozambique, acts of violence against elderly women often stem from accusations of witchcraft connected with unexplained events (WHO/INPEA, 2002). "Mourning rites of passage" for widows in parts of Africa and South Asia can include cruel practices, sexual violence, forced marriages, and eviction from their homes (WHO/INPEA).

An international study of the various forms of domestic violence, including abuse by adult children against their elderly parents, echoes many of these themes and suggests others (Malley-Morrison, 2004). The study, which used a common survey to explore family violence in twenty-four developing and developed countries, also emphasized the role of poverty, economic policies, the status of women, and historical oppression of minority and indigenous groups in family violence. Other contributing factors that were identified included substance abuse, low rates of literacy, laws or customs that permit physical discipline of children, and civil wars.

The emerging literature on global elder abuse also points out how cultural and religious values and traditions mitigate abuse and neglect, and it suggests approaches to abuse prevention (WHO/INPEA). Strong religious dictates to respect and care for older adults, particularly one's parents, have been cited as an important protective factor against abuse; and, in many countries, religious institutions care for destitute elders. WHO/INPEA focus group members in Kenya pointed out that traditional healers, who are key to religious practice and are typically elders, play an important role in society by providing an alternative to the health care system, which is underfunded, inaccessible to those who are poor, and often seen as corrupt.

Focus group participants in the WHO/INPEA study were further asked to suggest ways to stop elder abuse and neglect. Their recommendations included raising awareness, encouraging positive contact between generations, empowering elders to advocate on their own behalf, and providing recreational facilities and opportunities to combat isolation. Solutions to "structural problems" included the strong protective laws and improved health care.

In response, WHO/INPEA has proposed a global strategy that includes the development of a screening and assessment tool for use in primary health care settings, an educational package on elder abuse for primary health care professionals, the development and dissemination of a research methodology kit to study elder abuse, the development of a minimum data set concerning violence and older people, the dissemination of research findings, and a global inventory of good practices.

## CONCLUSION

Our field is still very much a work in progress. This chapter has pointed out some of the shifting paradigms and crosscurrents of thought, values, and ideologies that have defined, shaped, and influenced us. These developments further suggest new challenges and opportunities. I will conclude by pointing out a few of these challenges and opportunities, which are described again in greater detail in Chapters 9 and 10.

As we continue to stretch the limits of our community-based long-term care system to "reasonably accommodate" increasingly frail elders, we will need to devote significant resources and attention to reinforcing the protective service safety net. Specific needs that have emerged from the Olmstead decision and the consumer choice movement include the following:

- Mental health professionals to assess when frail elders need decision makers and advocates

- Training for service providers in how to assess capacity for common tasks and to recognize the need for more comprehensive assessment
- Advocates, guardians, or surrogates to act on behalf of those who are incapable of protecting themselves
- Assistance in finding, screening, and supervising independent home-care workers
- Adequate funding for APS and other investigators to monitor those at greatest risk and to respond to complaints of neglect and abuse
- Support services, including more personal care attendants, home-delivered meal programs, transportation, and so on

Ensuring protection for persons with diminished mental capacity is particularly critical and challenging. It will require further exploration into the needs of “unbefriended elders,” a term that is increasingly being used to describe elders with diminished mental capacity; who lack friends, surrogates, and advance directives; and who are at risk or in need of services or interventions (Karp & Wood, 2003). At present, few alternatives exist, other than guardianship, for people once they have lost capacity. Less restrictive alternatives are needed for those who are unable to consent to services or medical treatment, hire and supervise helpers, and stop or prevent abuse and neglect.

Recognizing that there are no one-size-fits-all fixes, we need to continue to take a multifaceted approach that holds perpetrators accountable, empowers victims, and ensures the safety, security, and freedom of the most vulnerable.

Holding perpetrators accountable for their actions through criminal justice interventions is imperative, and we must continue to explore new ways to make the criminal justice system more accessible and responsive to elders. We also need to be mindful of the system’s pitfalls, monitor its impact, and explore ways to use the leverage the system offers more effectively. Although arrest, incarceration, and court supervision of offenders are powerful tools for stopping abuse, the criminal justice system can achieve other important goals such as compelling offenders to pay back their victims and communities through restitution and community service and providing strong incentives for them to seek treatment.

The emphasis on holding perpetrators accountable, strengthening the criminal justice response, and empowering victims does not preclude offering support and assistance to abusive or high-risk caregivers, nor does it diminish the importance of social services, treatment, and protection for victims. New discoveries about the psychology of victimization suggest a wide range of interventions that hold promise for overcoming

social barriers, psychological manipulation, and intergenerational and long-standing family conflicts.

As the field evolves, we will need to continue to examine, clarify, and define APS workers' role and the viability of workers serving as both investigators and victim advocates. As the consequences of abuse become more severe, as the punishments for abusers increase, and as the repercussions of inaccurate assessments intensify, APS' role will come under increasing scrutiny and perhaps force us to reassess old assumptions.

Finally, there is much to gain from looking beyond our borders for new approaches and perspectives. This is particularly crucial in light of the fact that by 2025, the global population of people over the age of sixty is expected to reach 1.2 billion. One million people turn sixty every month, and 80% of these are in the developing world (WHO/INPEA, 2002). In addition, many of the themes raised in the international literature on elder abuse have been echoed by underserved and disenfranchised groups within wealthier countries. These include the necessity of viewing elder abuse within a broader social, political, and economic context and calling for holistic and integrated approaches that address the needs of families, extended families, cultural groups, and the broader community.

These challenges are formidable. Meeting them will require us to resolve the conflicts that have placed us in opposition to those whose approaches differ from ours. It will require broadening society's perspective on civil rights and liberties to encompass the full life span and exploring ways to ensure the rights and protection of people with diminished capacity. It means working with other advocates, including proponents of consumer choice, to explore ways to preserve independence and autonomy that do not pose unacceptable and needless risks. Just as we have expanded our network to include an ever-widening array of service providers, we need to extend our advocacy network. Failure to do so will lead to counterproductive battles, a lack of unity, incoherent policy, and missed opportunities.

## NOTES

- 1.The video, which was written and directed by Hilary Pryor and produced by The May Street Group Film, is available from Terra Nova Films. For more information, see <http://www.terranova.org/SearchResult.aspx?ListType=Title&IDValue=W>.
- 2.In developing countries, the term *primary health care workers* typically refers to nonphysicians, ranging from medical assistants and nurse practitioners to village "mobilizers," volunteers, or aides who combine modern health science and technology with traditional healing to address such basic health issues as family planning, pre- and postnatal care, nutrition, immunization, safe water, basic sanitation, and disease prevention. Most primary health care workers are women and are chosen with input from their communities.