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A Collaborative Approach
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*The author is not speaking on behalf of her employer and the views expressed are her own and do not necessarily represent an official position of her employer.

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New York

We dedicate this book to the memory of Rosalie Wolf. We also dedicate this book to the front-line workers, law enforcement officers, prosecutors, health care providers, advocates, civil attorneys, and others who work with elder abuse victims on a daily basis. Their commitment to assisting victims and ending elder abuse inspires us.

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Contents

Preface		xi
Introduction		xiii
Acknowledgments		xix

SECTION ONE: UNDERSTANDING ELDER ABUSE

ONE	**Historical Context**	**3**
	Historical Context	5
	Systems' Responses to Elder Abuse	7
TWO	**Defining Elder Abuse**	**17**
	Introduction	17
	Age	19
	Health and Functional Status of the Victim	20
	Gender	21
	Residence: Abuse Occurs at Home	22
	Relationship Between Victim and Abuser	22
	Forms of Elder Abuse	23
	Conclusion	35
THREE	**Dynamics of Elder Abuse**	**37**
	Why Does Elder Abuse Occur?	38
	Why Specific Forms of Elder Abuse Occur	44
	Why Does An Older Person Who Is Being Harmed Maintain a Relationship with the Abuser?	52
	Conclusion	57

SECTION TWO: RESPONDING TO ELDER ABUSE

FOUR	**Identification and Reporting**	**61**
	Identifying Elder Abuse	62
	Indicators of Elder Abuse	64
	Abuse and Neglect in Long-term Care Facilities	70
	Additional Guidelines for Effective Interviewing	74
	Reporting/Referring Elder Abuse	74
	Additional Considerations for Reporting/Referring Abuse in Facilities	76
	Conclusion	77
FIVE	**Systemic Responses to Elder Abuse**	**79**
	Adult Protective Services	79
	Criminal Justice System	83
	Civil Justice System	88
	Health Care System	89
	Domestic Violence and Sexual Assault Programs	93
	Long Term Care Ombudsman	96
	Additional Agencies That May Offer Useful Services for Elder Abuse Victims	96
	Conclusion	100

SECTION THREE: COLLABORATION

SIX	**Collaborative Efforts: Benefits and Obstacles**	**103**
	Overview	103
	Historical Perspective	104
	Collaborative and Noncollaborative Approaches to Elder Abuse	105
	Collaborative Approaches	107
	Types of Collaborative Efforts	110
	Advantages of Elder Abuse Collaborations	110
	Recognizing and Overcoming Obstacles	116
	Professional Visions and Philosophies	116
	Challenges Relating to Historical Distrust and Poor Prior Interactions	118
	Challenges Relating to Definition and Understanding of Elder Abuse	120
	Challenges Relating to Setting	121
	Challenges Related to Legal Requirements and Limitations	123

	Challenges Relating to Roles	124
	Challenges Related to Personality Conflicts	126
	Additional Challenges for Formalized Teams	127
	Team Member Obstacles	127
	Deviation From Accepted Procedures	128
	Long-term Team Sustainability	129
	Conclusion	130
SEVEN	**Effective Interventions and Informal Collaborations**	**131**
	Overview	131
	Informal Multidisciplinary Responses	131
	Case 1: Emotional and Physical Abuse and Financial Exploitation	132
	Effective Interventions Through Collaboration	134
	Case 2: Caregiver Neglect	139
	Guiding Principles: Empowerment and Self-Determination	142
	Case 3: Domestic Violence	143
	Case 4: Betty: A Case of Self-Neglect	146
	Guiding Principles in Facilities	149
	Case 5: Sexual Abuse in a Licensed Facility	149
	Conclusion	152
EIGHT	**Team Processes**	**155**
	Overview	155
	Steps of Team Processes	155
	Planning Phase	156
	The Work	164
	Evaluation	164
	Sustaining Team Effort	168
	Implementing Change Based on the Evaluation Results	169
	Conducting Strategic Planning	169
	Utilizing Data to Direct Research	170
	Dissemination of Information About the Team	171

SECTION FOUR: ACCOMPLISHING THE WORK

NINE	**The Work of a Case Management Team**	**175**
	Overview	175
	Phase I: Case Referral	175

	Phase II: Assessment or Investigation	179
	Phase III: Crafting an Interventiion Plan	182
	Phase IV: Implementation of the Intervention Plan	185
	Multi-Agency Case: Doris	190
	Single-Agency Case: Estelle	194
TEN	**Enhancing Victim Safety Through Collaboration**	**197**
	Elder Abuse Can Lead to Serious Harm or Death	198
	Case Illustration	212
ELEVEN	**A Collaborative Model for Holding Abusers Accountable**	**219**
	Law Enforcement	220
	Conclusion	236
TWELVE	**Systems Review and Change Through Multidisciplinary Collaborations**	**237**
	Introduction	237
	Importance of Systems Review and Change	238
	Conclusion	252

SECTION FIVE: WHERE DO WE GO FROM HERE?

THIRTEEN	**Strategies to End Elder Abuse**	**255**
	Need for Strategic Initiatives	256
	Advocating for Social Change	258
	Improving Services and Remedies for Current Victims	260
	Helping Future Victims by Expanding Knowledge Through Data Collection and Research	270
	Conclusion	276
APPENDIX A		**279**
REFERENCES		**283**
INDEX		**295**

Preface

Everyone, including older people, deserves to live in peace and dignity. This generation of older Americans has achieved some amazing accomplishments. They have contributed to and lived through significant changes. Some lived through the Depression and the rapid economic changes that have occurred in the last 50 years. Others served in wars, such as World War I or II, the Korean War, or Vietnam. Some influenced art, music, or literature. Others were involved in changes in technology, medicine, or space travel.

However, most older people lived quiet lives raising families and participating in their communities. They come from a variety of racial, ethnic, economic, and religious backgrounds. These elders were mothers or fathers, sisters or brothers, and represent the rich heterogeneity seen in older people. Some elders were wealthy, some indigent; some had white- or blue-collar jobs. As younger adults, some chose to be homemakers or to be self-employed. Others were unable to work because of physical or mental health problems, and some were chronically unemployed. Some suffered trauma early in life or throughout their lives.

Most older people are loved and cherished, but too many are isolated in facilities or living in loneliness and fear in the community. Some elders become physically or emotionally hurt, and others lose their financial resources or suffer neglect or abandonment. Regardless of their background or societal contributions, every elder deserves to live safely and with dignity, and all deserve protection and intervention to stop abuse when it occurs.

Reported cases of elder abuse are increasing. Victims encounter multiple systems, and they are best served when professionals from these systems work together. It is the responsibility of these professionals to work collaboratively to enhance victim safety, hold abusers accountable, promote systemic change, and advocate for new policy initiatives and legislation, additional research and funding, and social change. This book provides the framework to begin and to build on multidisciplinary approaches at the local, state, and national levels toward ending elder abuse.

Introduction

Professionals in a variety of systems are encountering increasing numbers of older victims and their abusers. Health care professionals are identifying more older patients who have been harmed. Reports of elder abuse to Adult Protective Services (APS) and law enforcement are rising. More offenders are being prosecuted and held accountable than ever before. As the population percentile of older Americans increases, greater numbers of seniors who have been abused are contacting advocacy programs such as domestic violence and sexual assault organizations. Many older adults are turning to the civil justice system for remedies to abuse.

The increase in numbers of older victims seeking help raises the question: how many elders are being abused? Unfortunately, no one knows for sure. Too few surveys have been done in this area, and those that have been completed suffer from serious methodological problems. For example, the National Elder Abuse Incidence Study, conducted in 1998 under the auspices of the National Center on Elder Abuse, reported that 551,011 persons over age 60 experienced some form of abuse or neglect (National Center on Elder Abuse [NCEA], 1998). The study estimate of domestic elder abuse is significantly lower than previous estimates for many reasons. The study was not designed to determine how much elder abuse exists, but, rather, to look at the proportion of cases reported to APS versus the proportion of cases that actually exist (Cook-Daniels, 1999; Otto & Quinn, 1999). In addition, the sample size for the study was extremely small. Only 20 counties in 15 states were used. In each county only 12 to 13 agencies were included, and each agency had typically only four to six trained sentinels (individuals responsible for the initial data collection). Data were collected for only two months and were based on 1,498 actual cases (Cook-Daniels, 1999; Otto & Quinn, 1999). Moreover, the study did not assess abuse of older persons in long-term care facilities or other institutions.

Currently, no single national entity collects and analyzes elder abuse data from the various sources. Existing data are compiled from state APS

programs, state Long-Term Care Ombudsman, regulatory agencies, and state Medicaid Fraud Control Units. One method used to determine the extent of the problem has been to look at data collected by APS agencies, because in most states, they are the primary responders to cases of elder abuse and abuse against vulnerable adults. For instance, the report titled *The 2004 Survey of State of Adult Protective Services: Abuse of Adults 60 Years of Age and Older* found that 565,747 reports of elder and adult abuse were made to APS in Fiscal Year (FY) 2003, a 19.7% increase from the 2000 Survey (472,813). Of this number, 32 states said that APS received a total of 253,426 reports on persons aged 60 and older. The majority of state APS programs serve vulnerable adults ages 18–59 in addition to people over 60. Because many states do not collect separate data on abuse victims age 60 and older, it is not possible to determine age-specific information from all 50 states, the territories, and the District of Columbia (Teaster, 2006).

A handful of smaller studies provide some information about the prevalence of the problem. In 1988, Pillemer and Finklehor, using a random sample method interviewing more than 2,000 older adults in Boston, estimated that between 701,000 and 1,093,560 older Americans are victims of abuse each year (Pillemer & Finklehor, 1988). These figures lead to estimates that 32 of every 1,000 elders in the United States were abused per year. Mouton, Rovi, Furniss, and Lasser (1999) found that 4.3% of the 257 women ages 50 and older who responded to a national health survey answered "yes" to questions about being currently in an abusive relationship. Harris (1996) reviewed the 1985 National Family Violence Resurvey and found that 5.8% of older couples had experienced domestic violence in the past year. Another study that examined APS records in Connecticut found that 1.6% of elders had been abused, neglected, or exploited over a nine-year period (Lachs, Williams, O'Brien, Hurst, & Horwitz, 1997). Hudson et al. (1999) found that 7.5% of surveyed elders had been abused at some point after turning age 65. In addition, Hudson and Carlson (1999) interviewed 917 people in North Carolina and found that 6.2% of adults stated that they had abused an elder.

Clearly, data and evidence from the field suggest that elder abuse is an increasingly serious problem in America. *But why focus a book on a collaborative or multidisciplinary response to elder abuse?* Each of the authors has been in his or her chosen field for more than 15 years. Several have witnessed elder abuse in their personal lives, often involving someone they cherish. Each of the authors has cases that haunt them—cases where their respective discipline failed an older victim.

For example, Helen was 72 years old when she came to the domestic violence shelter in 1983. All of the other residents were young women. To her dismay, Helen realized that she had been abused longer than any

of the other residents had been alive. Helen stayed for two weeks before returning home, telling staff she didn't see any other options.

In another case, during her first night in a nursing home, Muryl, age 86, had all of her rings stripped from her fingers while she slept. The nursing home staff said that they had fallen off and been lost in the bedclothes. The rings were never found. Several days later Muryl's family reported the incident to the police. They were told that law enforcement did not respond to problems regarding lost possessions that occurred in nursing homes.

Through our professional experiences, each of us has found that the expertise, services, and resources of our respective disciplines were, on their own, inadequate to enhance the safety of older victims. Advocates cannot make arrests. Prosecutors cannot mend broken bones. Each of us began to look for others who were willing to collaborate to provide a wider array of options than any single system could provide.

Each of us has participated in multidisciplinary work on the local, state, and national level. We have struggled through the challenge of working with professionals who have different mandates and agendas, as well as celebrated successes that came from collaboration to promote victim safety and to hold abusers accountable.

The co-authors of this book are from adult protective services, law enforcement, prosecution, health care, advocacy, and civil justice. Writing this book forced us to form our own multidisciplinary team. We shared a common goal—to write a book promoting elder victim safety through collaboration. We agreed on an outline and a target audience. Then the conflicts began.

Like any newly formed team, we found ourselves needing to establish ground rules and deadlines. We reviewed each other's writing and were amazed to find so many different perspectives and viewpoints. We struggled to define elder abuse. Should self-neglect be included? What about crimes and consumer scams against older people? What about abuse in facilities? Where did domestic violence fit in? In the end, we found consensus on these issues, as described in Chapter 2.

As authors, we struggled with voice. In keeping with our respective disciplines, we differed on how formal or informal the tone should be. Which studies should be included, given the methodological problems with most of the existing research? How much technical detail versus broad concepts was appropriate?

We decided to let the experiences of victims speak for themselves through case examples. Many of the chapters in this text include case presentations to illustrate the major points. These cases are based on actual circumstances, but not on actual patients, victims, or clients, and many of the scenarios are composites of multiple cases. The names are

fictitious and details about the lives of the victims have been eliminated; any similarity to an actual case is coincidental. However, elements of each example are based on elder abuse victims that we have encountered. First names were used for clarity, even though many seniors prefer to be addressed formally with their last name.

Language, including the use of jargon, was another source of contention. Should we use words such as *mistreatment, abuse, violence*, or *battering*? Are we talking about *victims, patients*, or *clients*? Is the harm caused by *abusers, offenders, perpetrators*, or *family members*?

In the end, we resolved these difficulties by allowing a voice for each author. Like any good multidisciplinary team, each member was encouraged to shine in her or his specialty area and, for that section, to use the language of that field. Other authors contributed additional text based on their expertise, providing further richness and depth.

Along the way, we recognized how much we still did not know about elder abuse. Too little research has been done. Studies are flawed. Too few resources and professionals are devoted to this issue. For the book to be more comprehensive, we wished we could have included additional authors with expertise in abuse in facilities, substance abuse, mental health, cultural competency, and a variety of other issues. Like any multidisciplinary team, we balanced the number of participants needed to get the job done versus having "too many cooks in the kitchen." We recognize that more could be said about some issues not fully addressed in this text.

One example of an issue we struggled with is abuse in long-term care facilities. The elder abuse field has historically separated the harm that occurs in the community (known as *domestic elder abuse*) from that which occurs in facilities, such as nursing homes, community-based residential facilities, or assisted living facilities (referred to as *institutional abuse*). Different systems of response were established; domestic elder abuse was generally considered the realm of APS (although some APS programs investigate suspected abuse in facilities), whereas regulatory agencies and Long-Term Care Ombudsman Programs dealt with institutional abuse. This distinction was logical in the early days, when the perception was that family members committed domestic elder abuse and facilities staff committed institutional abuse.

As the field has matured, however, perceptions about both forms of abuse have changed dramatically. Moreover, the systems of response have expanded and, to some extent, become less distinct. These changes have led many to believe that the line between domestic elder abuse and institutional elder abuse is largely artificial. The response to elder abuse should not depend on whether the roof over an older person's head is that of a private dwelling or a facility. In too many cases, that approach has meant that

victims of abuse who live in facilities have not had the benefit of responses by the justice system, APS, and advocacy organizations, such as domestic violence or sexual assault programs. Although we recognize that facilities have legal responsibilities to protect their residents from abuse, we believe that the types of abuse committed and the types of perpetrators who commit them should determine the response. Therefore, as the parameters for this book were plotted, we felt strongly the need to address elder abuse that occurred in any location to encourage collaboration in both domestic and long-term care settings. To illustrate: if a nursing home resident is abused by her spouse or raped by an employee of the facility, then responses from regulatory, health care, APS, long term-care ombudsman, criminal justice, and civil justice systems are necessary. But assistance from the domestic violence or sexual assault systems is also appropriate. The victim in a nursing home needs the help those systems can provide as much as when the abuse or rape occurs under the roof of a private dwelling.

That said, the idea of writing about institutional abuse created a dilemma. Each of us had done some work on abuse in facilities, but our primary work had been devoted to domestic elder abuse. Consequently, the discussions of institutional abuse are not as comprehensive as the discussions about domestic elder abuse. It was decided, however, that narrowing the scope to domestic elder abuse was a disservice to many older victims and in direct conflict with the primary message about collaboration.

By listening to each author's unique perspectives, the team ultimately gained greater understanding and awareness. This is not the book any one of us could have written individually. It is stronger because of the multidisciplinary approach.

To illustrate that point, one of the authors found a six-piece puzzle. She gave each of her co-authors one puzzle piece. The puzzle pieces served to remind the group that working in isolation meant that each could see just one piece of the mosaic. Only when the pieces were put together could the group see the full picture.

This book is divided into five sections. Section One describes the historical context, definitions, and dynamics of elder abuse. Section Two focuses on responding to elder abuse, including identification, reporting, and the systems involved in elder abuse cases. Section Three focuses on collaboration by discussing the definitions and benefits, obstacles to success, informal practice-based responses, and team process. Accomplishing the work of the team is addressed in Section Four. These chapters illustrate how a multidisciplinary approach enhances case review, victim safety, abuser accountability, and system change. Finally, Section Five examines policy, legislation, research, and social change needed to work toward ending elder abuse.

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—Carmel Bitondo Dyer

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—Candace J. Heisler

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—Randolph W. Thomas

SECTION ONE

Understanding Elder Abuse

CHAPTER ONE

Historical Context

Too often older Americans living in the community or in long-term care facilities (LTCF) are abused, exploited, and/or neglected. Relatives, partners or caregivers may steal money and treasured possessions. Lifelong partners who were abusive throughout the relationship continue their cruelty. Spouse/partners, adult children, and other family members or caregivers are the most common perpetrators of sexual assault and abuse (National Center on Elder Abuse, 1998). Seniors are told they are stupid or crazy, a common form of emotional abuse. Caregivers may neglect elders, leading to serious illness, harm, or death. Some older people do not, or are not able to, take care of themselves, a condition called self-neglect. In worse-case scenarios, older victims are killed by neglect, abuse, homicide, or homicide/suicide.

Reported cases of elder abuse are increasing. From 1986 to 1996, there was a steady increase in the reporting of domestic elder and vulnerable adult abuse nationwide, from 117,000 reports in 1986 to 293,000 reports in 1996. "This figure represents an increase of 150.4% since 1986" (National Center on Elder Abuse Web site). In 1998, the National Elder Abuse Incidence Study (NEAIS) suggested that only the tip of the iceberg of elder abuse cases are being identified (National Center on Elder Abuse, 1998). Two national studies of cases reported to Adult Protective Services (APS) in 2000 and 2004 that included both abuse of vulnerable adults and elder abuse found that during that period, there was a 19.7% increase in the number of elder/adult abuse reports in all 50 states, the District of Columbia, and three territories (Teaster, 2006).

Cases of elder abuse will continue to increase as Americans live longer. In the last 50 years, with advances in medical research, nutrition, health care, and modern conveniences, Americans are living longer than ever before and in greater numbers than previously experienced. Those numbers will continue to grow for at least the next several decades as the

baby boomers age. In 2000, thirty five million people were older than age 60 in the United States. This is an additional 3.7 million people or 12% increase since 1990. Nearly 1 in 8 persons (12.4%) of the population is at least 65 years old. By 2030, the numbers of older Americans will more than double to 70 million. Those ages 85 and older will increase from 4.2 million in 2000 to 8.9 million in 2030 (U.S. Census Bureau, 2004). Seniors are more likely to live with a disability, which has been shown to be a risk factor for some elder abuse (Lachs, Williams, O'Brien, Hurst, & Horowitz, 1997).

The number of older Americans from a variety of ethnic backgrounds is also rapidly changing. Elder abuse crosses all racial, ethnic, religious, and economic lines. In 2000, minority elders were 16.4% of the elder population. The percentage of elders from minority populations is projected to increase to 25.4% by 2030. Between 1999 and 2030, some populations will increase more significantly than others: Caucasian (81%), Hispanic (328%), African American (131%), American Indian, Eskimo, Aleut (147%), and Asians and Pacific Islanders (285%). All minority populations will increase by 219% (U.S. Census Bureau, 2004). This increase in persons from a variety of racial and ethnic groups will impact the types of programming that will need to be created to effectively intervene in cases of elder abuse.

Even as the numbers increase, professionals also recognize that elder abuse cases are complex and diverse. Some older victims are healthy and mentally alert. Others suffer from a variety of health problems, as well as physical and cognitive disabilities. Victims and perpetrators come from various racial, ethnic, economic, and religious backgrounds. Older victims bring a range of generational, cultural, and spiritual values about what constitutes abuse and what help they will accept. Abuse can occur in long-term or new intimate partner relationships. Family members and caregivers may also be offenders. The abuse may have been going on for years or started recently. The cause of abuse may be due to an organic condition, poor care giving, or the desire to gain and maintain power and control over the victim.

Some elder abuse is a crime that calls for a response from the criminal justice system. In other situations, such as self-neglect, social service workers, physicians, and other health care workers are more likely to offer effective interventions. Abuse occurring in facilities has its own complexity, as the abuser may be a family member, staff member, volunteer, or another resident. A variety of governmental agencies may get involved in abuse occurring in facilities.

A collaborative response to elder abuse is required. Multiple disciplines must work together to ensure a seamless response to victims that promotes their safety and well-being. This book helps professionals and others to

better understand the dynamics of elder abuse and methods that promote a collaborative response. Chapter 1 lays the groundwork for a collaborative approach by providing a brief history of the elder abuse field.

HISTORICAL CONTEXT

Family violence and sexual abuse, including abuse of older people, has been described in the literature for centuries. However, the naming and identification of child abuse, domestic violence, elder abuse, sexual assault, and abuse against people with disabilities and vulnerable adults are much more recent events. Child abuse was "discovered" in the 1960s by professionals working with victimized children. In the 1970s, both the sexual assault and battered women's movement emerged from grassroots efforts.

Although Burston identified the phenomenon of "granny battering" in a British medical journal (1975), elder abuse was barely acknowledged in the United States until 1978 (Bonnie & Wallace, 2003). Beginning in the 1980s, Congress focused increasing attention on elder abuse by holding a series of hearings and issuing several reports. It was not until February 2003, however, that a comprehensive federal response was initiated with the introduction of the Elder Justice Act by Senators Breaux and Hatch (Breaux & Hatch, 2002). The Act had not passed when the 108th Congress adjourned. It was reintroduced as S. 2010 by Senators Hatch and Lincoln in 2005 (Hatch & Lincoln, 2005).

Research on elder abuse has been scarce and underfunded. A few small studies were published in the 1980s and 1990s, but it was not until 1998 that the NEAIS was conducted by the National Center on Elder Abuse (NCEA) and Westat (National Center on Elder Abuse, 1998). Data from all 50 state Adult Protective Services programs, the District of Columbia, and Guam were collected in 2000 and again in 2004 (Teaster, 2006). In 2001, The National Academy of Sciences panel published "Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America" (Bonnie & Wallace, 2003). In 2001, the National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect reviewed and compiled a list of existing research in the field and called for more research in the field (Bonnie & Wallace, 2003). For a timeline of significant national events in the elder abuse field, see Appendix A.

The Federal Government's Response to Elder Abuse

The federal government has been slow to respond to elder abuse. Currently, not even one federal employee works exclusively on elder abuse issues (Breaux & Hatch, 2002). National funding on elder abuse is a fraction

of all federal spending on abuse. "The federal government spends $153.5 million on programs directly addressing issues of elder abuse. In sharp contrast, the federal government spends $520 million on programs combating violence against women and $6.7 billion on child abuse prevention efforts. Of the $153.3 million spent directly on elder abuse prevention, $143.34 million is spent through the Department of Health and Human Services, with the remaining $10.16 million being spent on Department of Justice programs" (Anonymous, 2002, p. 16).

The Department of Health and Human Services provides funding and programming through the Social Services Block Grant (SSBG) program and the Older Americans Act. Social Service Block Grant funds are used to support APS agencies in less than half of the states nationwide. The Older Americans Act provides funding through the Administration on Aging for the Long Term Care Ombudsman Program, Prevention of Elder Abuse, Neglect and Exploitation Program, and the NCEA. Also housed in the Department of Health and Human Services is the National Institute on Aging, the Centers for Medicare and Medicaid Services, and the Office of the Inspector General. The National Institute on Aging conducts some research related to elder abuse. The Centers for Medicare and Medicaid Services contract with state agencies to survey nursing homes and respond to complaints about abuse and services. The Office of the Inspector General funds the Medicaid Fraud Control Units that exist in all but a few states to investigate and prosecute cases of patient abuse, neglect, and exploitation in nursing homes and, in some states, to also investigate complaints in other types of LTCF including assisted living facilities and board and care homes (Anonymous, 2002).

The Department of Justice provides funding through several of its entities, including the Office on Violence Against Women, Office for Victims of Crime, Bureau of Justice Assistance, and National Institute of Justice. Since 2002, the Office on Violence Against Women has provided grants to train law enforcement, prosecutors, and court personnel on elder abuse and abuse against people with disabilities. The Office for Victims of Crime has funded a number of elder abuse initiatives aimed at improving the response to older victims of abuse and exploitation. The Bureau of Justice Assistance has supported efforts to educate law enforcement officers and prosecutors about elder abuse, and the National Institute of Justice has provided grants for studies on medical forensic issues related to elder abuse.

Additional Responses to Elder Abuse

Many national organizations and statewide and local initiatives have been created to address the needs of victims, hold abusers accountable,

improve policies and practices, and raise professional and public awareness. The primary national organization devoted to elder abuse issues is the NCEA, which was first funded in 1989 through the Older Americans Act by the Administration on Aging. Since 1998, the National Center on Elder Abuse has been administered under the auspices of the National Association of State Units on Aging with partners at the American Bar Association Commission on Law and Aging, the Clearinghouse on Abuse and Neglect of the Elderly at the University of Delaware, the National Adult Protective Services Association, and the National Committee for the Prevention of Elder Abuse. The mission of the NCEA is to "promote understanding, knowledge sharing, and action on elder abuse, neglect." Two other national projects worth noting are the National Clearinghouse on Abuse in Later Life and the National Long Term Care Ombudsman Resource Center. Both address a segment of elder abuse but are not partners of the NCEA.

There are also some notable statewide and local elder abuse programs throughout the country. Some of these local and statewide efforts are described in more detail later in the chapter. Many of these efforts grew out of a specific discipline such as the aging network, health care, or the criminal justice system; other projects use a collaborative model.

SYSTEMS' RESPONSES TO ELDER ABUSE

Over time a number of disciplines whose professionals are primary responders to elder abuse victims began working on this issue. This section describes the responses of the APS and elder abuse agencies, the criminal justice system, health care, domestic violence and sexual assault movements, and the civil justice system. Addressing abuse in long-term care facilities is also discussed. Historically, these systems have approached cases of elder abuse using the expertise from their own disciplines but have usually not worked collaboratively with professionals in other fields to respond to older victims.

Adult Protective Services/Elder Abuse Agencies

APS is the principal public source of first response to reports of elder and vulnerable adult abuse, neglect, and exploitation. (The definition of vulnerable adult varies based on state statute but, in general, vulnerable adults are persons 18 years and older who have physical or cognitive impairments that cause them to be unable to provide for their basic needs, protect themselves, or report abuse.) APS programs are empowered by states and local communities to accept and investigate reports of abuse,

neglect, and financial exploitation of elders and younger people with disabilities (Otto, 2002). The real impetus for states to provide APS came with the passage of Title XX of the Social Security Act in 1974. Broad language in the Act gave permission for states to use Social Services Block Grant (SSBG) funds for the protection of adults as well as children. By 1981, "all the states, in one way or another, noted that they had an office with responsibility to provide protective services to some segment of the population . . . providing such services to the needy even in the absence of authorizing legislation" (U.S. Congress 1981, p. 70). Absent federal direction on this issue, many states continued to adopt their own statutes for providing APS, which were usually delivered by state or local social service agencies (Otto, 2000). As state laws evolved, definitions became increasingly state specific, as did the programs. Currently, only six state APS laws do not have some sort of mandatory reporting requirement (Otto, 2000).

A continuing issue was the provision of protective services to self-neglecting persons with disabilities and elderly adults (Research Conference Recommendations, 1986). Researchers insisted that self-neglect was not a form of abuse, but APS practitioners recognized that self-neglecting adults made up the majority of their caseloads. Because the cases were complex and time-intensive, APS programs began to turn to other community agencies and to develop informal coalitions to meet the multiple needs of self-neglecting clients.

Criminal Justice System

The criminal justice system, and law enforcement in particular, has traditionally responded to calls relating to criminal conduct and community service functions, such as well-being checks. Responses to social problems, including family violence across the life span, were handled with little interaction with other systems. Historically, crimes against elders were dealt with by the criminal justice system, whereas elder abuse, neglect, and exploitation by family members in the home setting were seen as social service problems. "It became apparent in the last decade that although elder abuse was a public welfare matter and later taken over as an aging issue, it could also be viewed as a crime. Today, police officers, prosecutors, and health and social service providers realize that they all have an important role to play in preventing victimization of elders whether perpetrated by strangers or family members" (Wolf, 2000a, p. 1). Previously, where legal interventions were sought, civil, not criminal, courts were used.

Prosecutors have typically been reactive. They addressed cases that were investigated and presented by law enforcement, rather than

initiating and conducting investigations of family violence matters. It is not surprising that when few arrests for domestic violence and elder abuse were made, few prosecutions were initiated. Adding to the limited response, there was little training provided to criminal justice professionals on the investigation and prosecution of elder abuse cases. When victims declined to prosecute or wanted to drop charges, many agencies did not proceed. Many cases, including situations in which the victim had dementia or simply was believed to be confused, were not investigated or prosecuted. There were no specialized victim support services for older victims or specialized investigation or prosecution units.

Significant changes have occurred over the last decade in some communities. These new responses tend to be localized, although the National District Attorney's Association has now adopted a position that:

> given the numerous agencies and individuals that are involved with elders on a daily basis, the National District Attorneys Association recognizes that a multidisciplinary approach to prosecuting elder abuses cases should be considered. Individuals and agencies from the medical and financial fields, public health, service providers, and law enforcement should be involved, as appropriate, in a team effort to investigate, prevent, and prosecute elder abuse crimes. In order for the multidisciplinary approach to be successful, prosecutors must take a leadership role in these teams. (National District Attorneys Association, 1977)

Its research arm, the American Prosecutors Research Institute, APRI, has begun to develop information and research on national prosecution promising practices.

In various communities, specialized investigative and prosecution units have been established (NDAA, 2003). Some prosecutors' offices, such as San Diego, California; San Francisco, California; Seattle, Washington; and Cook County, Illinois, have established specialized elder abuse units. These units often have one prosecutor who works with a victim throughout the case, a process called "vertical prosecution." Training curricula and programs have been developed. Specialized victim advocates operate in some locations to serve elder crime victims (Heisler & Stiegel, 2002). Increased numbers of arrests and prosecutions are also occurring.

Civil Justice

The civil justice system handles an array of legal remedies that may be used to protect an older person from elder abuse or to respond to an elder who has already been victimized. These include claims for compensation due to harm or to recover financial losses resulting from abuse,

neglect, or exploitation; restraining orders or injunctions; divorce or separation; guardianship or conservatorship; mental health commitments; and attempts to undo a will, deed, contract, or other type of transaction because of fraud or undue influence.

There is not a large body of case law on elder abuse. Decisions relating to guardianships and conservatorships are not categorized as elder abuse cases. Other civil actions and remedies have either not been used, or not recognized or classified as elder abuse cases. Most civil legal decisions and verdicts are not documented in case law reports and therefore do not become a part of the body of case law precedent on which other lawyers rely in building subsequent cases (Stiegel, 2000).

Elder abuse victims usually do not turn to the civil justice system for a variety of reasons. These include reluctance to take legal action; practical problems such as difficulty traveling to or accessing a lawyer's office or courthouse, or the lack of understanding that there are civil legal remedies available; difficulty of proving elder abuse cases; the cost of bringing civil legal cases to court, and the challenges to obtaining and then actually collecting a recovery that exceeds the legal costs; the slow pace and customary delays of the civil legal process; and a lack of knowledge about and sensitivity to elder abuse victims by judges and other court personnel.

There are some sources of civil legal assistance for victims that may help to prevent victimization. Every community is expected to have a free government-sponsored legal services program for persons over age 60, as well as a legal services or legal aid program for persons with low incomes and few assets. Depending on funding and priorities, these programs may be able to help older persons avoid or respond to victimization. State or local bar associations may run volunteer lawyer programs that can provide similar services. Lawyers who work in law firms and charge for their services can also help older persons with civil matters related to elder abuse.

An increasing number of elder abuse cases, particularly those regarding nursing home abuses, are being heard and reported by the civil courts. This change is due to growing awareness by victims and their family members, new laws, increased training of lawyers and other professionals about old and new civil legal remedies, training of judges about elder abuse, and a growing recognition that elder abuse is a legal, as well as a social and health problem (Stiegel, 2000).

Medical Response to Elder Abuse

The medical response to elder abuse has been slow in coming. From the late 1970s, when Burston referred to "granny-bashing" in a *Lancet*

article, to the 1990s, physicians contributed little to the medical literature. Most considered it strictly a social problem and not within the purview of medicine. Awareness increased as social scientists began to perform more rigorous studies of the issue. A few academic centers around the United States now have active elder abuse research programs. Most of the published data are from epidemiologic analyses or descriptive clinical studies (Alpert, Tonkin, Seeherman, & Holtz, 1998; Hendricks-Matthews, 1997).

The inclusion of elder abuse in medical curricula has been inconsistent. A recent National Research Council report called for all health professional schools to educate their trainees about the issue of family violence, including elder abuse (Bonnie & Wallace, 2003). A recent report by the Institute of Medicine called for all health professional schools to educate their trainees about the issue of family violence, including elder abuse (Institute of Medicine, 2002). Four academic programs in different locales across the United States have started providing elder abuse training in the field with APS workers for professionals from a variety of disciplines (Heath, Dyer, Kerzner, Mosqueda, & Murphy, 2002).

Physicians and nurses have been providing clinical care to victims of elder abuse for years. When they recognize it, physicians generally consult with social workers to develop intervention plans. Geriatric teams have applied interdisciplinary geriatric assessment and intervention to victims of elder abuse as they do for other vulnerable elders.

Domestic Violence and Sexual Assault Movements

In the late 1980s, the connection was being made between domestic violence and elder abuse. In Wisconsin, the Department of Health and Family Services held a landmark conference bringing together participants from domestic violence and APS in 1988. In 1992, the American Association of Retired Persons (AARP) sponsored a national forum to address the needs of older abused women. As a result of this forum, AARP provided funding to the Wisconsin Coalition Against Domestic Violence (WCADV) to produce a document on the needs of older battered women and a directory of services. From 1994 to 1996, the United State Administration on Aging funded six national demonstration projects to examine the specific needs of older abused women and methods of collaboration to improve responses. In 1999, the WCADV received funding from the U.S. Department of Justice, Office on Violence Against Women, to open the National Clearinghouse on Abuse in Later Life. In 2000, the Violence Against Women Act provided grants to train law enforcement, prosecutors, and court personnel on elder abuse and abuse against persons with disabilities.

During the last decade, an expanded framework for understanding the dynamics of elder abuse emerged that recognized the presence of power and control dynamics in many cases. Domestic violence advocates recognized that existing services were not tailored to meet the needs of older abused women. In some communities, domestic violence programs hired elder abuse specialists and created older abused women's support groups. These programs are still scattered throughout the country, but modest improvements have been made in the availability of specialized services for older abused women. In other communities, such as Phoenix and San Francisco, abuse in later life programs have been created and sustained through the aging field. A national survey found more than 100 programs across the country that focus on abuse in later life and 34 support groups for older abused women (National Clearinghouse on Abuse in Later Life, 2003). Although some agencies working with people with disabilities have begun creating programs for victims of abuse, few of these services have been designed for older victims.

More recently, sexual assault programs have also begun to look at elder sexual abuse and to create written materials and services for older victims. The Wisconsin Coalition Against Sexual Assault has created several materials including a video on sexual abuse in later life.

The Response to Elder Abuse in Long-Term Care Facilities

The problem of elder abuse in nursing homes and other LTCF (referred to as "institutional abuse") has elicited attention from Congress, government agencies, the media, and advocacy organizations since Senator Frank Moss's seminal hearings in the 1960s (Anonymous, 2002). Like elder abuse occurring in the community, institutional abuse is underreported (U.S. General Accounting Office, 2002), and the extent of the problem is largely unknown (Anonymous, 2002).

LTCF residents may be physically or mentally incapable of reporting abuse. They or their family members and other visitors may fear that reports will result in increased abuse or retaliation. Even when reports are made, regulatory, investigatory, and advocacy agencies responses have often been inadequate (U.S. General Accounting Office, 2002).

Congressional hearings, government studies, advocacy by residents' family members, and media attention have led to significant changes in the response to institutional abuse. These developments include the creation of the Long Term Care Ombudsman Program, which provides advocacy for LTCF residents regardless of age and the establishment of the National Citizens Coalition for Nursing Home Reform. Ombudsman programs and other agencies have developed and implemented

training programs for LTCF direct care and administrative staff (Menio & Keller, 2000).

Responses to abuse in facilities have varied. Some states, including Georgia, have developed statutory reform initiatives. Efforts have been made to strengthen the regulatory process at the state and federal levels. The number of personal injury lawsuits for nursing home abuse has exploded, and it is now common to see lawyers specializing in nursing home abuse cases. Medicaid Fraud Control Units have been established in almost every state to investigate and prosecute abuse and exploitation in nursing homes, and their jurisdiction has expanded to include assisted living facilities. The U.S. Department of Justice established its Nursing Home Initiative, which supported federal and state criminal and civil actions against long-term care facilities through education of prosecutors, law enforcement officers, staff of APS and Long Term Care Ombudsman Program, and regulatory personnel, as well as through the development of state working groups composed of those professionals (Office of Justice Programs, 2000).

Multidisciplinary Approaches to Elder Abuse

Historically, systemic responses to elder abuse were not collaborative and often involved only a few systems that did not communicate effectively with each other. As professionals' understanding of the complexity of elder abuse has increased, more programs throughout the country are responding to elder abuse using a multidisciplinary approach that will be described and promoted throughout the remainder of this book. Some highlights of multidisciplinary approaches to elder abuse are described in this section.

Wisconsin, Oregon, Texas, and Louisiana have developed successful collaborative statewide efforts. Throughout the 1990s, Wisconsin formed a collaborative effort with the Department of Health and Family Services, Wisconsin Coalition Against Domestic Violence, Wisconsin Coalition Against Sexual Assault, the Coalition of Wisconsin Aging Groups, and others to focus on domestic violence and sexual assault in later life. In 1994, a task force in Oregon worked with and trained bank personnel to identify financial exploitation (Anonymous, 2002). The Texas Department of Protective and Regulatory Services created a public awareness campaign titled "Not Forgotten." The U.S. Department of Justice's Nursing Home Initiative has produced successful working groups in Louisiana and Virginia to identify and respond to substandard care in nursing homes (Anonymous, 2002).

Local multidisciplinary teams have been working together for many years. The Greater Cleveland Roundtable has focused on domestic abuse

in late life. The San Francisco Consortium staffed by the Institute on Aging works to "protect and maintain the health, independence, and safety of elders by providing a comprehensive range of services to vulnerable seniors aimed at preventing or responding to abuse or neglect" (Institute on Aging Web site, 2004). In Phoenix, Arizona, the Maricopa Elder Abuse Prevention Alliance was created in 1993 and now has approximately 100 professionals from a variety of disciplines working together on elder abuse and domestic abuse in later life (Area Agency on Aging, 2002). Both local efforts address elder abuse and have specific programming on domestic abuse in later life.

Several criminal justice initiatives are worth noting. A specialized law enforcement unit was established in Fresno, and specialized elder abuse units in both law enforcement and prosecution have been created in San Francisco, Ventura County, San Diego, and Los Angeles. Elder service officers focusing specifically on elder abuse exist in Cook County, Illinois (Chicago), Hillsborough County, Florida (Tampa), and the state of Louisiana. Louisiana has legislation that requires the designation of an elder abuse prosecutor in each judicial district, as well (Heisler & Stiegel, 2002). There are also TRIADs active throughout the country. TRIAD stands for the three sectors of a community that partner to keep seniors safe from crime: public safety, criminal justice, and seniors.

Specialized teams have been developed to address financial exploitation. These teams (often called Financial Abuse Specialist Teams or FAST) provide expert consultation and training to protective services and other professionals in cases of elder financial exploitation and assist in recovering or preventing further loss of assets. They also provide education and training on elder financial abuse. The Los Angeles FAST was convened in 1993 to combat elder financial abuse in Los Angeles County (Bernatz, Aziz, & Mosqueda, 2001). The Los Angeles FAST and similar teams across the country work closely with bank personnel to gather information and secure assets. Mental health specialists train team members to administer assessments to determine whether the older person is a victim of undue influence or has diminished capacity. Law enforcement officers train personnel on team members' legal rights and protections in disclosing information to investigators regarding suspected exploitation (U.S. Departments of Justice and Health and Human Services, 2000).

Medical response teams have also been created in several communities including Houston, Texas, and Orange County, California, to respond in a multidisciplinary manner to elder abuse. In the mid-1990s, several academic centers collaborated with protective service specialists, civil and/or criminal lawyers, police officers, and victim advocates to form specialized interdisciplinary geriatric assessment and intervention teams. The first formal medical response team began at the Beth Israel

Hospital in Boston, Massachusetts, in the 1980s. The purpose of this hospital-based team was to provide consultation and support to hospital staff, assist in a multidimensional evaluation of older victims of mistreatment, and develop treatment plans (Matlaw & Spence, 1994). In New York City, another hospital-based team was formed at Mount Sinai Hospital in 1998. This team serves hospitalized victims and assists them with counseling and other supportive services (Kahan & Paris, 2003).

In 1995, a geriatric medicine interdisciplinary team at Baylor College of Medicine, Houston, Texas, began collaborating with the APS of Texas and later became know as the Texas Elder Abuse and Mistreatment Institute (Dyer, Hyman, Pavlik, Murphy, & Gleason, 1999). Also in the mid-1990s, a similar team was established at the University of California, Irvine, called the Vulnerable Adult Specialist Team. Other academic medical centers, including the Robert Wood Johnson Medical School in New Jersey and the Hennepin Medical, Center, Minnesota, have also forged alliances with APS (Heath et al., 2002).

Since 2001, the elder abuse field has begun to develop fatality review teams, borrowing a concept that has been used successfully in the child abuse and domestic violence fields. The broad goal of elder abuse fatality review teams is to examine deaths caused by or related to elder abuse to improve the systems that respond to victims and prevent similar deaths in the future. There are currently eight elder abuse fatality review teams, which are located in Houston, Texas; Maine (statewide team); Orange County, California; Pima County, Arizona; Pulaski County, Arkansas; and Sacramento, San Diego, and San Francisco, California. Several other states and communities are in the process of establishing teams.

A multidisciplinary response is also beneficial in facility cases. Because LTCF administrators generally have a sense of when they will be surveyed and thus can prepare, a few states have developed collaborative projects such as Florida's "Operation Spot Check" or California's "Operation Guardian" to conduct random, unannounced inspections of LTCF.

As is evident in the discussion in this chapter, the elder abuse field is growing, and research and programming are emerging. The naming and identifying of elder abuse are relatively recent occurrences. Too little research has been done to grasp the prevalence and incidence of elder abuse. Congress and the federal government have touched on elder abuse but have failed to address the problem in any meaningful way. Yet, the work in the field on the local, state, and national levels has been impressive given the limited resources. Through the efforts of numerous dedicated professionals from a variety of disciplines, awareness of elder abuse and the development of promising practices and specialized programming increased significantly within the last decade.

Early efforts to respond to older victims used a "silo" approach, in which each discipline responded to cases, without working with others. Throughout the last decade, however, a multidisciplinary response is emerging and is now considered best practice. The next two chapters focus on defining and understanding the dynamics of elder abuse in order to lay a foundation for a multidisciplinary response.