Elder Justice

Curriculum Modules for MSW Programs

In response to the primary issues identified by the 2015 White House Conference on Aging (WHCOA), the Gero-Ed Center has collaborated with social work educators to develop teaching modules that address elder justice, healthy aging, long-term services and supports, and retirement security. The WHCOA noted that these four issues will greatly impact the aging landscape for older Americans over the next decade.

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Elder Justice Module 1:
An Overview: Abuse, Neglect, and Exploitation of Older Adults

Competencies Addressed

- Assess individuals, families, groups, organizations, and communities

Objectives

1. To define the major forms of elder abuse and their distinguishing characteristics
2. To identify potential risks factors of both the older adult and the perpetrator
3. To identify the signs of abuse and/or neglect
4. To increase knowledge of the major biological and social aging theories as applied to elder mistreatment
5. To apply theoretical approaches to assess and understand elder abuse

Introduction

Elder abuse is a multifaceted phenomenon that is both a subset of other social issues and a separate and unique challenge. Social workers in mental health, domestic violence, criminal justice, and health care settings need to recognize the potential for abuse, neglect, and exploitation of older clients or older family members of their clients. Elder abuse presents unique challenges in the area of financial exploitation and in the issues surrounding capacity and consent and the needs for long-term services and support (Greenlee, 2012). The growing aging population means that the number of abused and neglected older adults will increase as well, and all social workers need knowledge and awareness that will assist them in the recognition and assessment of potential abuse situations. Ageism and misinformation about the aging process may lead to erroneous assumptions about what constitutes "normal" aging. This module provides information on the aging process and major theories of aging in conjunction with information on abuse, neglect, and exploitation.

This materials herein may be incorporated into lectures or presentations that are intended to help students understand elder abuse in the context of aging processes and theories of aging taught in HBSE classes. Topics addressed include:

- Why Social Workers Need to Be Aware of Elder Abuse
- Definitions of Abuse, Neglect, and Exploitation of Older Adults
- The Aging Process and Risk Factors for Abuse
- Warning Signs of Elder Abuse
  - ◦ Elder Mistreatment Case Studies and Vignettes
- Theoretical Approaches to Understanding Elder Abuse

Why Social Workers Need to Be Aware of Elder Abuse

Available data suggest that one in ten older adults in the United States are mistreated or neglected (Acierno et al., 2010). Currently there is no definitive information on the incidence of elder abuse and neglect within ethnic and minority populations. This is important given the diversity of the U.S. population. Social workers can expect to encounter the abuse, mistreatment, and exploitation of older adults in many service settings including family services, health care settings, and services for seniors.

Every state in the United States has incorporated laws to protect dependent adults and the elderly. Social workers are mandated reporters of elder abuse and neglect. Adult Protective Services (APS) is the social services system charged with investigating and intervening in cases of abuse, neglect, and exploitation of vulnerable and older adults, with the goal of alleviating risk and their increasing safety and well-being. APS workers are often first responders. Many but not all APS caseworkers and investigators are professional social workers. The APS system in each state differs, but most APS programs are located either in county departments of social services or are affiliated with state departments of aging.

> Note: For information on the structure of APS and reporting laws in your state, visit the National Association of Adult Protective Services (NAPSA) website: http://www.napsa-now.org/get-help/how-aps-helps/.

The cases reported to APS are said to be the "tip of the iceberg" of elder mistreatment (National Center on Elder Abuse, 1998). A 2011 study that combined a population-based survey of community-dwelling older adults with a study of elder abuse (excluding self-neglect) reported to community-based agencies in New York State found that for every case reported, 24 cases were not reported (Lifespan of Greater Rochester Inc., Weill Cornell Medical School of Cornell University, & New York City Department for the Aging, 2011). Reports of self-neglect are the most common reports to APS and account for the vast majority of cases in most states (Teaster et al., 2006). Neglect by caregivers is the second most common category; however, in recent years, concern about financial exploitation of older adults has increased as the number of reports of financial exploitation has continued to rise. The diversity of potential responses to each type of mistreatment means that social workers must be aware of normal aging processes and risks associated with aging, theories of aging, and the signs of elder abuse and neglect.

Definitions and Indicators of Abuse, Neglect, and Exploitation of Older Adults

Elder Abuse Definitions

Along with initiatives to increase the ability of professionals to recognize and respond to elder abuse, efforts have also been made to provide definitions that will help clarify what constitutes abuse. Because definition of the problem determines the response to the problem, awareness that different definitions are used by different service systems and in different contexts is important. Definitions of elder mistreatment must consider issues related to age (there is no universally accepted definition of the point when a person becomes an "elder"), health and functional status of victim, gender, location (whether the abuse occurred in the home or in a facility), and the relationship between the victim and the abuser (Brandl et al., 2006). Other considerations are whether the abuse is a form of domestic or intimate partner violence and whether the victim is dependent on someone else for care (Nerenberg, 2008). Older adults may

also experience two or more types of mistreatment. Recently, the field has begun to use the term "polyvictimization" to describe this phenomenon.

The definitions below are adaptions of those provided by the National Center on Elder Abuse, which serves as a resource for policy makers, social service and health care professionals, advocates, and older adults.

Type	Definition
Physical abuse	Inflicting, or threatening to inflict, physical pain or injury on a vulnerable older person, or depriving the person of a basic need.
Sexual abuse	Non-consensual sexual contact of any kind; coercing an elder to witness sexual behaviors.
Emotional or psychological abuse	Inflicting mental pain, anguish, or distress on an older person through verbal or nonverbal acts.
Neglect	Refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable older person.
Abandonment	The desertion of an older person by an individual who has assumed responsibility for providing care.
Financial or material exploitation	Illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable older person.
Self-neglect	The behavior of an older person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. It does not include instances where a mentally competent older person as a matter of personal choice makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety.

Source National Center on Elder Abuse: http://www.ncea.aoa.gov/faq/index.aspx

A number of excellent resources provide overviews of definitions, programs, and services related to elder abuse and elder justice.

Web Resources	
Center of Excellence on Elder Abuse and Neglect	http://www.centeronelderabuse.org/
National Center on Elder Abuse	http://www.ncea.aoa.gov/
The New York City Elder Abuse Center	http://nyceac.com
Ageless Alliance	http://www.agelessalliance.org/
National Clearinghouse on Abuse in Later Life	http://www.ncall.us/
National Committee for the Prevention of Elder Abuse	http://www.preventelderabuse.org/
National Adult Protective Services Association	http://www.napsa-now.org/
International Network for the Prevention of Elder Abuse	http://www.inpea.net/
National Resource Center on LGBT Aging	http://www.lgbtagingcenter.org/index.cfm
Administration on Aging	http://www.aoa.gov/AoA_programs/elder_rights/EA_prevention/whatisEA.aspx
National Institute on Aging	https://www.nia.nih.gov/health/publication/elder-abuse
National Council on Aging	https://www.ncoa.org/public-policy-action/elder-justice/

The Administration on Aging's (AoA) document, *How to Answer Those Tough Questions about Elder Abuse*, provides definitions of elder abuse and summarizes risk factors and other important information.
(http://www.ncea.aoa.gov/Resources/Publication/docs/ToughQuestions_2012.pdf)

The Aging Process and Risk Factors for Abuse

Biological Aging

Aging is a process that begins at birth and is the normal continuum of the life course development. The process is not an indicator of disease. It is important to recognize what changes are part of normal aging; what are the results of disease, abuse, disuse, and misuse; and what can be prevented. Normative aging, for the mature adult, includes biological changes such as declines in the functioning of hearing, vision, skin-elasticity, regulation of body temperature, hair color, and hair loss. Normative aging is also reflected in a slowing of biological systems. The rate of decline is related to the individual's genetic predisposition, environment, and lifestyle. Genetic changes may be an option for the future, but a lifestyle including moderate exercise and a healthy diet can delay the decline of functioning. The perception that disease is associated with

aging is inaccurate. Disease is more often related to extended exposure to elements that can cause disease. For example, lung cancer is a disease that may not develop until later life due to a lifetime of exposure to pollution, smoke, and/or asbestos. Heart disease, the leading cause of death for the older adult, may be prevented by exercise and a healthy diet and is not due to normative aging.

The role of a social worker is not to diagnose disease but to evaluate the older adult's ability to live autonomously and to assist in creating and coordinating interventions that will help the client to maintain his/her choice of living situation and quality of life for as long as safely possible. When the older adult can no longer live safely at home, then the role of the social worker is to assist them in transitioning into a more supportive environment. Social workers need to acquire knowledge of normal aging processes in order to differentiate biological changes in the aging body from possible indicators of abuse, neglect, and exploitation. See Handout of Changes Due to Normal Aging and Potential for Abuse and Neglect (located at the end of this module).

Understanding normal aging, particularly the increased incidence of chronic illness and disability, is key to identifying the risks that older adults face. An older adult can remain fit and healthy well into his/her nineties; but as functional abilities and mobility declines, the risk of abuse and neglect increases. As physical or mental capacities diminish, the older adult becomes increasingly dependent on others for assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). ADLs consist of the ability to complete independently the tasks of eating, transferring, toileting, bathing, and dressing/grooming. IADLs consist of the ability to complete independently the tasks of meal preparation, transportation, housekeeping, shopping, money management, medication management, and the use of the telephone. The older adult may not have enough social supports to meet their or their caregiver's needs, which may lead to frustration for both the elder and the caregiver. While caregiver stress is not the primary cause of elder abuse, it does increase the risk of mistreatment, particularly when older adults are living with dementia.

As noted above, reduced mobility can increase the risk of abuse. Injury due to falls can be a significant factor in declining mobility and functioning. Falls are the leading cause of injury and injury-related deaths of older adults in the United States. One in three Americans over the age of 65 falls each year. Many factors increase the risk of falls: e.g., impaired vision or equilibrium, loss of muscle mass and brittle bones, medication reactions, alcohol abuse, incontinence, use of assistive devices, and hazards in the household environment. Of those who fall 20% to 30% suffer moderate to serious injuries and risk ending up in long-term care facilities (National Center for Injury Prevention and Control, 2015).

Medication mismanagement is another risk factor associated with aging, especially when older adults are taking several medications to manage multiple chronic conditions. It is important to recognize that the physiological changes that accompany aging can interfere with the rate of absorption, metabolism, and elimination of medications. Medication interactions can cause adverse reactions, such as disorientation, disequilibrium (thus increased risk of falls), cognitive impairment, and possibly death.

The primary problem in medication management is compliance. Factors like cognitive impairment or financial insecurity can lead to medication misuse, underuse, overuse, or not taking prescribed medications at all. Family caregivers are not always equipped to manage complex medication regimes, resulting in medical neglect. Withholding prescribed medication is considered a form of physical abuse (http://elderabuse.stanford.edu/). For more information

and resources about medication management, visit the AoA website: http://www.aoa.gov/AoA_Programs/HPW/Med_Manage/index.aspx.

Another risk associated with declining abilities in older adults is social isolation. Incontinence and decreased mobility are key factors increasing the likelihood that an elder will withdraw from social activities. Without social activities or social support systems in place, the elder is at greater risk for all forms of abuse.

Risk Factors for Abuse, Neglect, and Exploitation

A combination of individual, relational, community, and societal factors contribute to the risk of becoming a victim or perpetrator of elder abuse. The extent to which older adults are at risk for abuse varies depending upon life circumstances, health status, functional abilities, and disability status. The characteristics of older adults, considered alone, provide insufficient explanations for the occurrence of elder abuse and neglect (Tomita, 2006). In determining whether an elder is at risk, the social worker must consider characteristics of the victims and perpetrators, the nature of their relationship, and the immediate and larger social environment that may be reliably associated with elder mistreatment and neglect, including self-neglect (Johannesen & LoGiudice, 2013). Understanding risk factors is important in identifying opportunities for preventive interventions and in identifying mistreatment of any kind.

To some extent, different risk factors are associated with different forms of elder abuse. In the National Elder Mistreatment Study, Acierno and colleagues (2009) found these links: older adults with physical disabilities had increased risk of financial exploitation; those who were low income, in poor health, and had weak social support systems were more likely to experience neglect. Another important finding in their study was that perpetrators who were unemployed, substance abusers, or had mental health problems were at elevated risk for engaging in several forms of abuse—including physical, emotional, and sexual.

Important risk factors that were identified in research at the end of the last century continue to be valid areas for ongoing research. Among them are a lack of social support for the person who was victimized, along with the potential for social isolation of the victim or perpetrator, or both; aggression or inappropriate actions by the victim toward the caregiving perpetrator; a perpetrator's substance abuse (or other pathological behaviors); and the victim's poor or declining health and functional capacity

According to the National Center on Elder Abuse, women and the oldest-old (80 years old and older) are more likely to be victimized, and mistreatment is most often perpetrated by the a victim's family members. Women tend to be at greater risk of abuse than men due to their longevity of life and because of gender-based power dynamics that often underlie mistreatment. The current life expectancy for women in the United States is 81 years. This longevity increases the likelihood of physical and functional decline and increases the likelihood of dependence on others.

Studies of intimate partner violence have generally been focused on young populations; thus, research among older couples is relatively limited. This disparity is problematic since partner violence may have more adverse effects on physical and mental health and may be more severe among older partners than among younger ones.

Women are the most frequent victims of partner violence, although men also are abused. In addition to the difference in rate of abuse, older women are more likely than older men to not report abuse (Logan Walker, Jordan, & Leukefeld, 2006). As a compounding factor, one study

found that more than 50% of older women victims experienced multiple types of abuse during their lives (Bonomi et al., 2007).

Intimate partner violence among older adults falls into three types: ongoing violence in a long-term relationship (the most common), violence early in a new relationship (often among those recently widowed or divorced), and late-onset violence in a long-term relationship (this can be associated with a victim's dementia, which leads to personality changes and violent outbursts and behaviors toward the caregiving spouse, who then retaliates physically).

The service needs of older women who experience intimate partner violence may be similar to those of younger women. However, the older women may face barriers to receiving help from traditional domestic violence (DV) agencies (e.g., shelters for abused women) if those agencies do not have the expertise to respond to their age-related needs (Kilbane & Spira, 2010). Some research studies have pointed out the service gaps.

The Domestic Violence against Older Women Study found that 134 older women who participated in focus groups faced both internal and external barriers to accessing services from DV agencies. Internal stressors included the need to protect their families, including the abuser, and a sense of self-blame and shame that had increased over the course of a long marriage (Beaularier, Seff, & Newman, 2008). Family members (non-perpetrators) were often non-supportive, and clergy failed to refer the women to DV agencies or the justice system. The participants questioned the efficacy of restraining orders and anger management classes for abusers, and they were reluctant to go to shelters, where they would have to co-exist with mothers with small children, or to services that would advocate their separation from their abusers. Some also voiced fears of being ridiculed or mistreated by the justice system.

A study that compared younger and older women who accessed DV services in Illinois (Lundy & Grossman, 2009) found that older women were less likely than younger women to be physically abused and to be abused by their husband/intimate partner. Older women were less likely than younger women to be self-referred, referred by a friend, or an abuse hotline, and more likely than younger women to be referred by the State Attorney's office. Older women received significantly more hours of help for criminal legal advocacy but fewer hours of individual and group counseling than younger women received.

> Note: The National Clearinghouse on Abuse in Later Life (NCALL — http://www.ncall.us/) has resources to address the unique needs of older victims of intimate partner and domestic violence.

LGBT older adults comprise a growing share of the aging population. The relatively few research studies on the prevalence and incidence of elder mistreatment among this group in community–based settings have provided important results. LGBT elders experience high rates of victimization because of their sexual orientation (e.g., verbal abuse, threat of violence, physical and sexual assault, threat of orientation disclosure), with men more likely to be physically abused than women (Fredriksen-Goldsen et al., 2011). A survey of 3500 LGBT elders 55 years old and older evaluated various types of abuse: 8.3% of respondents reported abuse or neglect by a caregiver, and 8.9% had experienced financial exploitation (Frazer, 2009; National Center on Elder Abuse, 2015). Mistreatment in institutional settings, especially of transgender individuals, has also been documented (MAP, SAGE & CAP, 2010).

LGBT victims of domestic violence may find it difficult to seek help, especially older adults who have internalized homophobia or tried to hide their sexual orientation. They may be anxious about the risks of coming out: personal, familial, and societal. And victims of domestic violence

may fear that reporting abuse will lead to further discrimination, especially in light of their limited social support networks (MetLife, 2011; National Center on Elder Abuse, 2015; SAGE, 2011).

Risk Factors for Perpetration of Elder Abuse

The perpetrators of elder abuse can be spouses/partners or other caregivers (primarily adult children or other family members). The results of a recent study indicated that most abusers were spouses or partners, not adult children (Acierno et al., 2010). Although the findings concerning the perpetrator status may be inconsistent, the risk factors for becoming a perpetrator are well documented. Caregiver stress, for example, is not the primary cause of mistreatment; a small percentage of abusers are caregivers overwhelmed by stress (Brandl & Raymond, 2012; Brintnall-Peterson, 2012). In fact, mistreatment is most often connected to power inequities between the caregiver and care recipient and to the caregiver's emotional or behavioral problems (e.g., mental illness, alcohol or drug dependence, hostility, a history of disruptive behavior, anger and resentment toward and social isolation from the older person). When power inequities are involved, more often than the reverse, the abuser is dependent on the victim financially or emotionally (Brandl & Raymond, 2012; Tomita, 2006). To date, little has been done to develop intervention or prevention programs for perpetrators of abuse of older adults; instead, the primary focus of government agencies has been on mandatory reporting, criminal investigation, and prosecution.

The following risk factors are characteristics associated with those who have perpetrated elder abuse (Centers for Disease Control Division of Violence Prevention: http://www.cdc.gov/violenceprevention/elderabuse/riskprotectivefactors.html).

Individual Level:

- Current diagnosis of mental illness
- Current abuse of alcohol
- High levels of hostility
- Poor or inadequate preparation or training for caregiving responsibilities
- Assumption of caregiving responsibilities at an early age
- Inadequate coping skills
- Exposure to abuse as a child

Relationship Level:

- High financial and emotional dependence upon a vulnerable older adult
- Past experience of disruptive behavior
- Lack of social support
- Lack of formal support

Community Level:

- Limited, inaccessible, or unavailable formal services, such as respite care for those providing care to vulnerable older adults

Societal Level (a culture with the following characeristics):

- High tolerance and acceptance of aggressive behavior
- Health care personnel, guardians, and other agents have personal control over routine care-provision and decision-making
- Family members expected to care for older relatives without help from others
- Persons encouraged to endure suffering or remain silent regarding their pains
- Negative beliefs about aging and older adults

In addition to the above factors, some specific characteristics of institutional settings may increase the risk for perpetration of abuse of vulnerable elders in these settings, including unsympathetic or negative attitudes toward residents, chronic staffing problems, lack of administrative oversight, staff burnout, and stressful working conditions. A recent study revealed that one in five nursing home residents have been involved in resident-to-resident mistreatment, including verbal or physical abuse, inappropriate sexual behavior, and invasion of privacy (Weill Cornell Medical College, 2014).

Warning Signs of Elder Abuse

The 2004 survey of State APS agencies, which reported results for 32 of the 50 states, documented 253,426 incidents involving elder abuse (including self-neglect) in 2003 (Teaster et al., 2006). The most common reports to APS involving older adults are cases of self-neglect. The mix of reports of other types of mistreatment may depend upon the jurisdiction. APS addresses more cases of caregiver neglect, financial exploitation, and psychological and emotional abuse than cases of physical or sexual abuse. Reports of neglect or self-neglect often involve the elder living in isolation or in unsafe or unsanitary living conditions. More information is provided below about the types and warning signs of elder abuse.

Self-Neglect

Self-neglect is a complex issue that social workers who work with older adults will see in varying degrees and forms. As defined above, self neglect is the behavior of an older person that threatens his/her own health or safety, which generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. However, there is disagreement about whether self-neglect should be included in definitions of "elder abuse." Many state statutes include self-neglect as a form of elder abuse, whereas the federal Elder Justice Act and advocacy organizations such as the National Clearinghouse on Abuse in Later Life do not because an ongoing relationship of trust with the abuser is part of the definition of "elder abuse." Because self-neglect often co-occurs with elder abuse and because at times the line between neglect by caregivers and self-neglect is difficult to draw, it is important to be aware of how self-neglect manifests in older adults.

Self-neglect may be present if no other adult is identified as the caregiver or as responsible for the older person, and the older adult appears to be unable to ensure necessary self-care (McInnis-Dittrich, 2014). Self-neglect can manifest itself through an older adult's health behaviors, appearance, and the appearance of the housing. Health behaviors include ignoring symptoms of a disease, failure to pay attention to medical needs, or endangering health behaviors such as smoking while on oxygen. Appearance includes dirty, unkempt clothing, dirt-

encrusted nails, and body odor. Household appearance includes unsanitary conditions, disrepair, hoarding (discussed below), and large numbers of pets.

Social workers recognize that older adults retain their rights to autonomy. The challenge is that social workers must balance their respect for the client's self-determination (autonomy) with their commitment to protect clients from harm. When legally appropriate, social workers must respect a client's wishes if the client clearly understands risks she/he is taking and the client is making independent choices. In situations involving other family members, the social worker must determine whether the caregiver/other family member is the primary source of risk or whether it is the older adult putting himself or herself at risk. The social worker must try to determine whether the indicators of neglect are attributable to the failure of others to provide care, or to the older adult's choices. Often, this is not an easy determination to make.

The warning signs of self-neglect reveal that it encompasses many domains — or areas — of a person's life, including physical, psychological, financial, social/cultural, and environmental. Examples include:

- Refusal to leave home to visit a doctor's office, clinic, or hospital
- Lack of medical care for a prolonged period of time
- Inability or refusal to see physicians
- Possible underdiagnosis, overmedication, or inadequate care
- Pressure ulcers
- Inability to manage finances (e.g., pay bills on time)
- Debilitated homes
- Filth
- Signs of malnutrition

An unsafe living environment due to neglect or inability to maintain one's property is one sign of potential self-neglect. Thanks to "Hoarders," the television series, which has aired since 2009, the American public is more familiar with the phenomenon of hoarding, which creates an unsafe living environment. Even before the series aired, social workers whose jobs involved home visits to clients were all too familiar with community members who hoard their possessions to the extent that their mental and physical well-being is threatened. Hoarding, which used to be considered a variety of obsessive compulsive disorder in the DSM-IV, now has its own definition in the DSM-V. Gail Steketee, a social worker who has conducted extensive research on hoarding, defines it as, "The acquisition of and failure to discard a large number of possessions that appear to be useless or of limited value including newspapers, magazines, old clothes, bags, storage containers, books, mail, boxes, and lists and memorabilia" (Steketee & Frost 2003, p. 906). This behavior usually has harmful emotional, physical, social, financial, and/or legal effects. Hoarding goes beyond normal collecting behavior in that the possessions fill the spaces of the person's home, making the space unusable and hazardous. It can affect people of any age, but the health and safety of older persons may be at increased risk from the consequences of hoarding (Steketee, Frost, & Kim, 2001). Extreme, longstanding hoarding creates unsafe conditions that may constitute a public health and safety threat in addition to the safety threat to the older adult (Chapin et al., 2010). People who hoard may live for many years without being noticed, but may come to the attention of the public when dangerous situations occur, such as a fire, problems with rats or mice, structural hazards (e.g., a porch so full of stuff that is collapses), or plumbing that no longer functions (Nerenberg, 2010). Or, concern about self-neglect or elder abuse may

bring the problem to the attention of APS. In the worst cases, hoarding can result in death or homelessness of the older adult and harm to neighbors or family members.

Resources on hoarding include:

MASTER Curriculum, San Diego State University: Working with Self Neglecting Clients (http://theacademy.sdsu.edu/mastercurriculum/working-with-self-neglecting-clients-instructor-led-training/).
Self-neglect can manifest itself through a variety of behaviors and characteristics, including hoarding, which is addressed in these training materials. Contains a link to a 10 minute video (https://www.youtube.com/watch?v=CMEWT1AWhq0) where people who hoard are interviewed by Randy Frost, a psychologist who is an expert on hoarding.

These articles are case studies on hoarding:

Andersen, E., Raffin-Bouchal, S., & Marcy-Edwards, D. (2013). "Do They Think I Am a Pack Rat?" *Journal of Elder Abuse and Neglect, 25*(5), 438-452. doi: http://dx.doi.org/10.1080/08946566.2013.770317

Franks, M., Lund, D. A., Poulton, D., & Caserta, M. S. (2004). Understanding hoarding behavior among older adults: A case study approach. *Journal of Gerontological Social Work, 42*(3/4), 77-107. doi: 10.1300/J083v42n03_06

Neglect by Others

Until recently, neglect by caregivers, which is the refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable older person, was the most common form of elder abuse perpetrated by others that was reported to APS. In recent years, reports of financial exploitation have increased (discussed in greater detail below).

Neglect is potentially lethal. To understand caregiver neglect, it is helpful to use a risk and vulnerability framework, which focuses on the vulnerabilities of the older person (e.g., health or functional status), the risks presented by the environment, including the caregiver, and the interaction between the two (Fulmer et al., 2005). The framework provides a way to consider the combination and interaction of different individual and environmental characteristics that result in the neglect of an older adult. These considerations help social workers understand that an older adult may be reluctant to leave a familiar situation, even if it is life-threatening.

Case Study:

Dee is an 85-year-old woman with arthritis and congestive heart failure that limit her mobility. She lives with and financially supports her 55-year-old daughter Linda who has a history of bipolar disorder and substance abuse. Although the relationship is often strained, the two have lived together for the past ten years because Linda is unable to function on her own, and Dee wants her to be safe. While Linda depends on Dee, Dee now also depends on Linda to manage her ADLs, and would no longer be able to live at home if Linda weren't there. Linda is often unable to cope with her mother's needs, and she often leaves Dee in bed all day rather than help her get up. Dee has now developed pressure sores on her back. Linda no longer helps her to bathe and often leaves Dee lying in her own waste. Dee is in danger and may want help, but she also does not want Linda to be punished.

The warning signs of neglect by caregivers — poor personal hygiene, untreated pressure sores, persons with dementia wandering unsupervised — are similar to those of self-neglect. At times,

as in the case of Dee, the older adult is the only household member in poor condition, while in other situations of extreme poverty, whole families may be living in appalling conditions (McInnis-Dittrich, 2014). Although neglect and self-neglect may share some of the same warning signs, the responses to neglect by caregivers are different than the responses to self-neglect (Shugarman, Fries, Wolf, & Morris, 2003). The response to neglect also depends upon the caregiving circumstances. Caregivers may be overwhelmed or lack the necessary knowledge to provide care, or they may be deliberately withholding necessary care, or the situation may reside somewhere on the continuum between the two.

Warning signs include:

- Lack of basic hygiene
- Lack of adequate food
- Lack of medical aids (e.g., glasses, walker, teeth, hearing aid, medications)
- Lack of clean appropriate clothing; stained or torn clothing
- Person with dementia left unsupervised
- Bed-bound person left without care
- Home cluttered, filthy, in disrepair, or having fire and safety hazards
- Home without adequate facilities (e.g., stove, refrigerator, heat, cooling, working plumbing, and electricity)
- Untreated pressure "bed" sores
- Dramatic weight loss
- Malnutrition or dehydration

Source: Center of Excellence on Elder Abuse and Neglect resources: Red Flags and Community Fact Sheet (http://www.centeronelderabuse.org/Advocacy_and_Policy_Change.asp).

Financial Exploitation

Financial exploitation, which involves the misappropriation of an older person's money or property by someone that the older person trusts, is a serious and costly threat to the safety and well-being of older adults. The incidence of financial exploitation has been growing, and recent studies show that it is now the most common form of elder mistreatment (Peterson et al., 2014). APS agencies also have documented increased reports of financial exploitation, particularly since the Great Recession of 2008 (Walls et al., 2011). Financial exploitation covers a wide range of activities. Some older adults are victims of consumer fraud, which occurs when individuals or businesses engage in deceptive practices that result in financial loss to the older adults, such as a telemarketing scam. Health care fraud, particularly Medicare fraud, is a growing concern. Older adults need to be aware of potential exploitation related to their Medicare benefits. For example, home health providers may file false claims that exaggerate patients' medical conditions or bill for unnecessary services. Some perpetrators of fraud obtain the Medicare numbers of older adults under false pretenses and then bill for services not actually rendered. Another type of health care fraud is medical identity theft, where the older adult's health information is used to obtain services and prescription drugs for someone else (http://www.justice.gov/elderjustice/practitioner/types-of-financial-exploitation_.html).

Family members can abuse older adults financially in a number of ways. For instances, they can "live off" the older adult's Social Security payments or pressure the older adult to lend them

money, change their will, or turn over the deed to their house. In an example of how financial exploitation may combine with neglect (sometimes referred to as polyvictimization), family members may forgo needed home health care or other medical services in order to preserve the older adult's financial resources for later inheritance. The line between exploitation and willing consent to share resources may be difficult to determine due to cognitive impairment of the older adult, coercion by the caregiver, or the older adult's concern about what will happen to the perpetrator if the exploitation is revealed.

Warning signs include:

- Lack of amenities victim could afford
- Elder "voluntarily" giving inappropriate financial reimbursement for needed care and companionship
- Caregiver has control of elder's money but is failing to provide for elder's needs
- Caretaker "living off" elder
- Elder has signed property transfers (Power of Attorney, new will, etc.) when unable to comprehend the transaction
- Standard of living is inconsistent with known income
- Unusual banking activity
- Signatures on checks don't match elder's signature
- Belongings are missing
- Bills are unpaid although elder's income is sufficient

Source: Center of Excellence on Elder Abuse and Neglect resources: Red Flags and Community Fact Sheet (http://www.centeronelderabuse.org/Advocacy_and_Policy_Change.asp).

Psychological Abuse

Emotional or psychological abuse is inflicting mental pain, anguish, or distress on an older person through verbal or nonverbal acts. More than other types of mistreatment, emotional abuse is hard to define and characterize, in part because one must consider not only the psychologically abusive behavior and its perceived effects on the older adult. Recent efforts to develop a self-report measure of psychological maltreatment resulted in the identification of four major types of psychological abuse – isolation, threats and intimidation, insensitivity and disrespect, and shaming and blaming. These researchers concluded that isolation was the most serious type of psychological abuse because it borders on physically abusive behavior when it involves physical restraint (Conrad, Iris, Ridings, Langley, & Anetzberger, 2011).

Warning signs include:

- Caregiver isolates elder (doesn't let anyone into the home or speak to the elder)
- Caregiver is verbally aggressive or demeaning, controlling, overly concerned about spending money, or uncaring
- Caregiver treats the elder like a child
- Elder is confused and anxious; or refuses to answer questions in front of a caregiver.

Source: Center of Excellence on Elder Abuse and Neglect resources: Red Flags and Community Fact Sheet (http://www.centeronelderabuse.org/Advocacy_and_Policy_Change.asp).

Physical Abuse

Physical abuse is inflicting, or threatening to inflict, physical pain or injury on a vulnerable older person, or depriving the person of a basic need. Physical abuse often co-occurs with other types of mistreatment. While neglect is an act of omission, physical abuse involves harmful action on the part of the perpetrator. Physical abuse can occur in the context of relationships where the perpetrator is dependent upon the older adult for support, as when an adult son "living off" his mother physically harms her (Jackson & Hafemeister, 2011). Physical abuse in caregiving relationships may occur when the older adult care recipient who has dementia is verbally or physically aggressive, particularly if the prior relationship with the caregiver was strained (Cooney, Howard, & Lawlor, 2006). In the past decade, there have been more efforts to train doctors and other first responders in how to screen for physical abuse and other types of mistreatment, so that they will report it to APS. Doctors and others are often reluctant to ask about the source of injuries because there are multiple potential causes, and doctors have not been consistently trained to recognize and report abuse (Yaffe, Wolfson, Lithwick, & Weiss, 2008). For example, bruises, one marker of physical abuse, may have other causes as well. Research on bruising in older adults has aided in distinguishing bruises resulting from abuse from those acquired in other ways; older adults who were mistreated were more likely to know the cause of their bruise, their bruises were larger, and they were located mostly on the face, arms, and back (Wiglesworth et al., 2009).

Warning signs include:

- Inadequately explained fractures, bruises, welts, cuts, sores, or burns
- Elder has repeated unexplained injuries
- Wearing long sleeves on a very hot day
- Elder refuses to go to the emergency room

Source: Center of Excellence on Elder Abuse and Neglect resources: Red Flags and Community Fact Sheet (http://www.centeronelderabuse.org/Advocacy_and_Policy_Change.asp).

Sexual Abuse

The same ageism that prevents many from seeing older adults as sexual beings may also blind social workers and others who come into contact with older adults to the possibility that older adults may be sexually abused by care providers, family members, and, in institutions, by other residents. Sexual abuse encompasses nonconsensual sexual behaviors that include unwanted sexual touching, involuntary nudity, sexually explicit photography, and sexual assault of all types (McInnis-Dittrich, 2014). Burgess and colleagues (2008) found that markers of sexual abuse (i.e., signs that triggered reports to APS or law enforcement) included strong ambivalence of the older person towards suspected offenders, victim's distress during personal care, signs of physical trauma, and sexually transmitted diseases. Sexual behaviors or statements made by suspected offenders also triggered investigation.

The difficulty in obtaining data on sexual abuse has impeded progress in learning about this topic (Teaster & Roberto, 2004), and existing research relies on reviews of cases that come to the attention of APS or the criminal justice system. Research suggests that sexual abuse, even when identified, does not receive the attention it deserves. A study of 82 older adults reported to APS, the majority of whom were women with cognitive impairment living in nursing homes, found that the majority of the incidents were perpetrated by other facility residents and involved

sexualized kissing and fondling and unwanted sexual interest. Only four cases were prosecuted (Teaster & Roberto, 2004).

Warning signs include:

- Unexplained vaginal or anal bleeding
- Torn or bloody underwear
- Bruised breasts
- Venereal diseases or vaginal infection
- Difficulty walking or sitting
- Inappropriate, unusual, or aggressive sexual behavior

Source: National Committee for the Prevention of Elder Abuse (http://www.preventelderabuse.org/elderabuse/s_abuse.html).

Social workers (except in New York State) are mandated by law to report any suspicions of abuse or neglect/self-neglect towards dependent adults or seniors to APS. More information about APS is presented in Modules 2 and 3.

Elder Mistreatment Case Studies and Vignettes

The following resources for case studies and vignettes are useful.

Anetzberger, G. J. (2005). Elder Abuse: Case Studies for Clinical Management. *Clinical Gerontologist, 28*(1-2), 43-53. doi: http://dx.doi.org/10.1300/J018v28n01_03

Contains three case studies. The first describes a woman who is socially isolated and engages in self-neglect;the second concerns a woman providing inadequate care for her dying spouse, a man who had been physically and emotionally abusive during their marriage; and the third describes a middle-aged woman caring for her mother who has Alzheimer's disease.

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

The author is the granddaughter of a couple who were abused and neglected by her uncle. It describes her efforts to intervene in the situation with the help of APS and the police, and her grandparents' repeated refusal to accept help. Illustrates factors involved in abuse, neglect, and self-neglect, including the perpetrator's substance abuse, financial exploitation of his parents, horrendous living conditions, and the declining capacity of the older couple to choose the course of action that was in their best interest.

U.S. Department of Justice Elder Justice Initiative – Scenarios
http://www.justice.gov/elderjustice/support/common-scenarios.html

These common abuse scenarios can be used as examples of different types of elder abuse.
http://www.justice.gov/elderjustice/financial/common-scenarios.html
These vignettes describe common scenarios of financial exploitation.

Theoretical Approaches to Understanding Elder Abuse

Social workers use various theoretical approaches to understand the aging process and elder abuse. Overviews of biological, social, and developmental theories of aging are helpful in providing further context on the aging process (see, for example, Hutchison [2015], McInnis-

Dittrich [2014], or other social gerontology or HBSE textbooks). Case vignettes can be used to draw connections about how theories would explain or add to understanding of specific situations involving elder abuse.

While various theoretical approaches have been used to understand elder abuse, few have been tested empirically. In a National Institute of Justice Research Brief, Jackson and Hafemeister (2013) provided an excellent overview of the process of theory development and the theories that have been used to understand elder abuse. They note that theory development in elder abuse has been limited because it has not been a priority for federal funding and has relied on a caregiver stress model for explanation. They also point out that different types of elder abuse (e.g., neglect, physical abuse, financial exploitation, psychological abuse, sexual abuse) require different theoretical explanations and attention to characteristics of both victim and perpetrator. This work can be found here: https://www.ncjrs.gov/pdffiles1/nij/241731.pdf.

Short descriptions of theoretical approaches that have been used to understand elder abuse are provided below. These can be categorized as interpersonal (social exchange and caregiver stress theories); intrapersonal (social learning theory); sociocultural (power and control theory); and multisystemic (ecological theory) (Burnight & Mosqueda, 2011). Developmental theories (attachment theory, Erikson's lifestage development theory, and life-course perspective) can also provide insight. Social workers need to be aware of the multi-dimensional nature of elder abuse in seeking and critiquing theoretical explanations.

Social Exchange Theory

Social exchange theory suggests that there is a set of mutual expectations that governs our relationships. Successful relationships are based on reciprocal benefits, and the parties to the relationship will positively evaluate the interactions. A parent cares for a child not only out of love but also as an investment for future security in old age. The child in return takes care of the aging parent out of obligation and love. However, older adults who need physical care or who want to remain in the community are often abused by their offspring who are dependent upon them financially or emotionally. Social exchange theory might predict that the older adult would seek an end to this uneven relationship, when in reality many older parents remain devoted to the care of their child or they are unable to leave the situation because they would be institutionalized (Jackson & Hafemeister, 2013).

Caregiver Stress Theory

Caregiver stress theory suggests that stressors on the caregiver cause the caregiver to lash out against the older adult. Factors related to caregiver stress are motivation for caregiving, lack of supportive services, lack of coping skills, lack of resources/respite, isolation of the victim, and outside stressors (job, losses, etc.). One criticism of caregiver stress theory is that it may lead to intervention strategies that inadvertently blame the victim or minimize the need for offenders to be accountable for their behavior. And as noted above, caregiver stress by itself is not a primary cause of mistreatment (Brandl & Raymond, 2012). On the other hand, because research on caregiver characteristics is scarce, social workers must continue to develop their understanding of the role of caregiver stress in elder abuse (Dong, Chen, Chang, & Simon, 2013).

Power and Control Theory

Power and control theory focuses attention on the abuser's use of coercion and threats to maintain power and control during the course of a relationship with another person. This theory

sees the abuser-victim dynamics from the domestic violence perspective. If spousal abuse of the older adult is regarded as elder abuse as opposed to domestic violence, proposed interventions may focus on relieving caregiver stress rather than protecting the victim from the perpetrator, and the abuse may continue. For a power and control theory diagram applied to abuse in later life, see http://www.ncall.us/content/abuse-later-life-power-control-wheel.

Social Learning Theory

Social learning theory suggests that the social environment to which the individual is exposed influences behavior. If a male child is exposed to parental aggressive or violent behavior as a means of conflict resolution, he is more likely to resort to spousal abuse as an adult. If the female child is exposed to parental aggressive or violent behavior as a means of conflict resolution, she is more likely to become a victim. The social learning theory suggests that if the elder has a history of violence in the family dynamics, there is a greater likelihood of abuse.

Ecological Perspective Theory

The ecological theory perspective acknowledges the impact that the environment has on the individual. For the older adult, the influences of the social environment can be seen in the lack of services and resources that are needed for their continued autonomy. Affordable housing, transportation, and medications are often a problem for older adults who are living on a fixed income. Older women are at a higher risk for poverty than men, with the oldest old (age 85+) women being the most at risk. Older individuals living alone are likely to be poor (Administration on Aging, 2013).

Developmental Theoretical Frameworks Applied to the Older Adult

Attachment Theory:

Bowlby's attachment theory discusses the importance of early childhood attachments to primary caregivers to provide a secure foundation from which the child can explore his/her physical environments and social engagements. Secure attachments are associated with higher self-esteem and sense of well-being. Attachment theory can be applied to the older adult's reaction to stress (physical, environmental, and loss) and their ability to cope. Attachment behavior patterns are often broken down into three categories: secure, avoidant, and anxious. Securely attached personalities will seek out interaction during times of great stress. Avoidant personalities tend to be wary or mistrustful of intervention by others. Anxious personalities tend to become dependent on others.

All three personality types can become victims of self-neglect and/or abuse, although the risk may be higher for the avoidant and anxious personalities. The avoidant personality may be more resistant to intervention, and the anxious personality may be more at risk for all forms of abuse because of their dependence on others.

The attachment theory can be useful when viewing caregiving patterns of the adult child now providing care for their parents. Attachment theory proposes that the ability of adults to form loving relationships throughout the lifespan will be reflected in the older adult providing care for a spouse.

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Erikson's Developmental Milestones:

Erikson recognized that human development continues throughout the life span and defined the tasks of each stage of life in terms of crises. Erikson suggested that the crisis of old age involves ego integrity versus despair. This stage of life is characterized as a time of reflection on and acceptance of one's life. Ego integrity enables the positive self-review of one's accomplishments and failures and the acceptance of both. Despair is associate with a negative self-review, resulting in regret, self-contempt, and a fear of death.

Life Course Perspective:

The life course or life span perspective views life as being fluid, multifaceted, contextual, entailing continual development and growth. This perspective states that old age is the continuation of life experiences, social roles, transitions, history, and adaptations —a time of entering the culmination period of life.

Other Useful Perspectives

Health Perspective:

The health perspective looks at the individual's concepts of aging, health, well-being, healthcare, and medication usage. This perspective is important when assessing the older adult's attitudes towards aging, the presence of disease, pain, and physical or cognitive declines. It is important to remember that not all older adults have had the same benefits or access to a lifetime of medical care.

Maslow's Hierarchy of Needs:

Maslow's hierarchy of needs states that to reach self-actualization basic needs must first be met. In working with the older adult, this framework can be useful in determining whether there are indications of neglect or abuse. Are the older adult's basic needs being met? Is the older adult safe? Is he or she isolated?

Strengths Perspective:

The strengths perspective evaluates the abilities, skills, and motivation of the older adult. This perspective focuses on identifying the adaptive abilities and coping mechanisms over the lifetime and utilizing these strengths to achieve the client's goals. Although the focus is on strengths, it is important to acknowledge the client's limitations so that mutually agreed upon interventions are attainable.

Summary

Understanding elder abuse and neglect is challenging because of the multi-faceted needs of older adults and the complex intra- and interpersonal dynamics involved. Each situation is unique, and social workers must be made aware that victims of abuse can range from frail, dependent, and cognitively impaired older adults to healthy older adults who may be in abusive relationships with their spouses or other family members. The growing number of older adults, the fact that one in ten of them may be a victim of abuse, neglect, or exploitation, and the consequences of abuse compel social workers to learn about definitions, risk factors, and warning signs of abuse, neglect, and exploitation. Armed with knowledge of normal aging processes, social workers can recognize and be sensitive to possible signs of abuse and neglect.

Although no one theory satisfactorily explains elder abuse, the theoretical perspectives summarized in this module provide a way to understand the dynamics involved.

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Handout 1

Changes Due to Normal Aging and Potential for Abuse/Neglect

AGING PROCESS CHANGES	NORMAL AGING OUTCOMES	LINKS TO POTENTIAL ABUSE
Skin Loss of skin thickness Atrophy of sweat glands and decreased blood flow Increased wrinkles and laxity of skin	Skin becomes paper thin Decreased sweating, loss of skin water, dry skin	Immobilization and neglect may cause bedsores, skin infection, bruises, skin laceration (potential for physical abuse)
Lung Decreased lung tissue elasticity Decreased respiratory muscle strength	Reduced overall efficiency of gases exchanged Reduced ability to handle secretions and foreign particles	Immobilization and neglect may cause lung infection Decreased stamina may result in dependence and isolation
Heart changes Heart valves thicken Increased fatty deposits in artery wall Increased hardening, stiffening of blood vessels Decreased sensitivity to change in blood pressure	Decreased blood flow Decreased responsiveness to stress, confusion, and disorientation Prone to loss of balance	Potential for falls/injuries, physical and psychological abuse
Gastric and intestinal Atrophy and decreased number of taste buds Decreased gastric secretion Decreased gastric muscle tone	Altered ability to taste sweet, sour, salt, and bitter Possible delay in vitamin and drug absorption Altered motility Decreased peristalsis Decreased hunger sensations and emptying time	Mal/under nutrition Fecal impaction (potential physical abuse) Change in how medications are absorbed, resulting in possible over-medicating, resulting in falls, confusion, etc.
Bladder Decreased bladder muscle tone and bladder capacity	Increased residual urine Sensation of urge to urinate may not occur until bladder is full Increased risk of infection, stress incontinence Urination at night may increase Enlarged prostate gland in male	Incontinence along with immobilization and neglect may cause skin breakdown and/or bedsores Potential for falls and injuries when having to get up more at night unassisted Incontinence is the single most predictive factor for abuse

AGING PROCESS CHANGES	NORMAL AGING OUTCOMES	LINKS TO POTENTIAL ABUSE
Muscles, joints, and bones Decreased muscle mass Deterioration of joint cartilage Decreased bone mass Decreased processing speed and vibration sense Decreased nerve fibers	Decreased muscle strength and increased muscle clamping Greater risk of fractures Limitation of movement Potential for pain	Immobilization and neglect may cause contracture deformities (potential for physical and psychological abuse) Increased potential for falls More likely to fracture under less impact than a bone of a younger person Less strength resulting in increased isolation and dependence on caregiver
Sensory Changes in sleep-wake cycle Slower stimulus identification and registration Decreased visual acuity Slower light and dark adaptation Difficulty in adapting to lighting changes Distorted depth perception Impaired color vision Changes in lens Diminished tear secretion Decreased tone discrimination Decreased sensitivity to odors Reduced tactile sensation	Increased or decreased time spent sleeping Increased nighttime awakenings Delayed reaction time Prone to falls Increased possibility of disorientation Glare may pose an environmental hazard Incorrect assessment of height of curbs and steps Presbyopia (diminished ability to focus on near objects) Presbycusis (high frequency sounds lost) Less able to differentiate lower color tones (e.g. blues, greens) Dullness and dryness of the eyes Decreased ability to sense pressure, pain, temperature	Neglect and social isolation (potential for financial abuse) Falls, fractures and injuries (potential for physical and psychological abuse)
Immune system Decline in secretion of hormones Impaired temperature regulation Impaired immune reactivity Decreased basal metabolic rate	Decreased resistance to certain stresses (burns, surgery, etc.) Increased susceptibility and incidence of infection Increased incidence of obesity	Bedsores Infections Fractures Isolation Dependence

AGING PROCESS CHANGES	NORMAL AGING OUTCOMES	LINKS TO POTENTIAL ABUSE
Mental and cognitive Some cognitive and mental functions decline Some cognitive skills (including judgment, creativity, common sense, and breadth of knowledge and experience) maintained or improved Some cognitive skills (including abstraction, calculation, word frequency, verbal comprehension, and inductive reasoning) show slight or gradual decline.	Short-term memory declines but long-term recall is usually maintained Difficulty understanding abstract content Learning abilities change — older adults are more cautious in their responses; are capable of learning new things but their speed of processing information is slower.	Potential for financial abuse and exploitation Increased risk for self-neglect

Source: California State University, Los Angeles, School of Social Work (2003). Adult Protective Services Worker Training for The California State Department of Social Services.

Elder Justice Module 2:
Social Work Practice with Abused, Neglected, and Exploited Older Adults

Competencies Addressed

- Demonstrate ethical and professional behavior
- Engage individuals, families, groups, organizations, and communities
- Assess individuals, families, groups, organizations, and communities
- Intervene with individuals, families, groups, organizations, and communities

Objectives

1. Gain a broader perspective on the ethical dilemmas associated with the older adult, particularly as they relate to elder abuse and neglect
2. Understand the importance of autonomy and independence for the older adult
3. Learn how to assess for capacity/make referral for capacity assessment
4. Understand the responsibilities of protecting the vulnerable adult and reporting abuse/neglect
5. Learn to identify potential risk factors for the older adult during the assessment process
6. Learn about community resources in place to address abuse and neglect

Introduction

Social work practice with older and disabled adults who have been abused, neglected, or exploited requires sensitivity and skill. Social workers may be confronted with an older adult who is being harmed by her adult child or another family member, yet that person may be unwilling to accept services for fear of alienating her loved ones or giving up independence. Social workers need to have an understanding of decision-making capacity and undue influence. Furthermore, social workers need to be aware of the health and social services available in the community, and be skilled in presenting the social work perspective within a multidisciplinary team. In this module, the discussion of working with abused, neglected, and exploited elders begins with an overview of social work values and ethics, because these inform and guide the assessment process.

Topics addressed include:

- Vignette
- Ethics and Values
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Vignette

To prepare students to discuss considerations and challenges for engagement, assessment, and intervention with older adults who may be abused or neglected, show the "Elder Abuse Video Enactment" found at the NYC Elder Abuse Center's (NYCEAC) website (http://nyceac.com/quick-clips/). This brief excerpt depicts an older woman in a wheelchair interacting with her son who is her caregiver and who is verbally abusive towards her. This video will help students in thinking about the types of family dynamics and caregiving situations they might encounter in practice. The website also includes videos of responses to the vignette by a variety of professionals to help the student consider how different people would respond, depending upon their professional role.

Have the students discuss what they observe in the video and the questions that the video raises about working with older adults who are experiencing abuse.

Ethics and Values

All social workers face ethical dilemmas in the course of their practice. Working with older adults, particularly those who are frail and vulnerable, can deeply challenge our personal values and professional ethics. It is essential that the social worker is aware of his/her own personal beliefs and value systems, the client's beliefs and value systems, social work values, societal values, and professional ethics. Our values and beliefs guide our views and interactions with the client. It is essential for a social worker to seek out the guidance, experience, and knowledge of a supervisor when confronted with personal conflicts or ethical dilemmas. Good supervision is vital to preserving the boundaries of social work values and ethics.

It is helpful to start with a review of core social work values, and then discuss the implications of these values for working with older adults, particularly in instances where the social worker suspects mistreatment.

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NASW Core Social Work Values

1. Service: Social workers must be committed to the service of people in need and work to resolve social problems.
2. Social Justice: Social workers must confront social injustices and oppressive practices and work to affect positive changes.
3. Dignity and Worth of the Person: Social workers must respect the dignity of all human beings.
4. Importance of Human Relationships: Social workers acknowledges the importance of interactions and relationships.
5. Integrity: Social workers will conduct themselves in an honorable, ethical and trustworthy manner.
6. Competence: Social workers must be competent in their practice, continue to develop their skills and their expertise in all realms of knowledge (cultural diversity, gender, age, sexual orientation…), and aspire to contribute to the knowledge base of the profession.

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Ethical Responsibilities

1. Commitment to Client: Social workers have a primary duty to promote and preserve the client's interests above all other parties.
7. Self-Determination: Social workers must acknowledge the client's right to make his/her own decisions and promote autonomy.
8. Informed Consent: Using language that the client will understand, social workers should inform the client of the services they can provide, the limitations of and alternatives to those services, the costs of the services, and the limitations to confidentiality. When the client lacks capacity to give informed consent, social workers must seek the consent of an appropriate third party.
9. Competence: Social workers must practice within their competencies and seek to remain current with and promote social work education, practice skills, and theory applications.
10. Cultural Competence and Social Diversity: Social workers must recognize the importance and impact that culture and diversity have on the client as well as their own cultures and diversity and society at large.
11. Conflict of Interest: Social workers must acknowledge any conflict of interest that may affect the client's best interest, and if it cannot be resolved, social workers must provide alternate resources for the client.
12. Privacy and Confidentiality: Social workers must respect the trust relationship that is established between the social worker and client. Information obtained from the client or while engaged in the service of the client is not to be disclosed without the client's knowledge unless otherwise mandated by law. (The social worker must break confidentiality if there is evidence that the client is in imminent danger or another party is in imminent danger by the client or if there are allegations of abuse to a minor, a dependent adult, or an elder.)
13. Termination of Services: Social workers have an obligation to transition the client throughout the process of termination upon completion of services or in the event a

specific social worker can no longer continue to provide services for the client and must transfer the client to another service provider.

When dealing with elder mistreatment, the core values of social work may become very difficult to carry out. Older adults want to preserve their autonomy, sometimes in the face of evidence that they are being abused or exploited by their caregivers or other relatives. The core value of self-determination and respect for autonomy may leave a social worker feeling as if her client is in danger of being abused or exploited by an adult child if the older adults chooses not to do anything such as ask the family member to move out. Some social workers may struggle over whether to break confidentiality and report abuse if they are concerned that their client will terminate services in response.

Values, Beliefs, and Attitudes

Values and beliefs are what guide us as human beings, and these carry over into every aspect of our lives. In working with older adults, social workers need to evaluate how they feel about the older population, growing old, physical decline, loss, disability, elder abuse, elder abusers, dying, and death. Negative attitudes toward aging or older people may result in a social worker's inability to see old age as a continued time of growth. The social worker may not be able to acknowledge the strengths, motivation, goals, ability to learn and grow, resilience, and adaptability of an older client. The social worker may be tempted to "save" the older person without adequately considering the consequences of actions taken to protect that person, which may include loss of home and independence.

Certain positive attitudes toward older persons may also influence how we interact with them. A stereotypical attitude that all older people are sweet and cute is dismissive and denies the value and complexity of the individual. An attitude that if he/she has lived this long let him/her do what they want can result in the social worker not recognizing behaviors that can be detrimental to the person. For example, you may encounter an older adult who abuses alcohol, and think, if Mr. Jones is 75 years old and wants to drink who is he hurting? You must keep in mind that alcohol abuse increases health risks, adverse medication interaction, and risks of falls. Additionally late-onset drinking may be an indicator of depression.

On the other hand, the social worker must focus on who the client is and what his/her self-determined goals are. Often the referral source is a family member or other interested party, but once the client consents to services, the social worker's obligation is to the client. Although what the client wants may be in conflict with other interested parties, the client's right to self-determination is primary, with the exception of issues related to safety and capacity. Capacity assessments are discussed in this module.

Case Study:

For example, suppose you are a social worker who works at a nursing facility where many clients come for rehabilitation after a stroke or hip replacement. One of your jobs is discharge planning — helping to make sure that the client's transition back to her home environment will go smoothly. You do this by working with the patients, family members, and informal and formal care providers. Mrs. Smith is your client, who is recovering from a stroke. She has lost much of the use of one arm, and while her condition has improved, she will need assistance with bathing, toileting, and other activities of daily living.

During a family meeting, Mrs. Smith's daughter Linda insists that Mrs. Smith come and live with her. She has enough room for Mrs. Smith, and Linda's husband and teenage daughter

are available to help. Linda insists that it will be less expensive as well. You are concerned about Mrs. Smith's need for care and companionship, and want to explore whether this is an option for her. Mrs. Smith says she would like her daughter to visit her every day instead.

When you are alone with Mrs. Smith, she reports that although she may need assistance, she is not ready to give up her home and her independence. You ask more questions and find out that on several occasions Linda has tried to pressure Mrs. Smith into putting her house in Linda's name, because she "will inherit it eventually." Linda would like to sell the house and use the proceeds for her daughter's college education. You also sense that something else bothers Mrs. Smith. After some gentle probing, you find out that Linda's husband is unemployed and that he has a substance use disorder. His volatile temper and abusive treatment of Linda make Mrs. Smith very uncomfortable.

The social worker's role is to respect the client's choice and to assess his or her ability to choose. Knowing Mrs. Smith's desires and concerns, you work to arrange home health and other services. When she learns that her mother wants to remain in her own home, Linda becomes very angry. In a family session Linda tells Mrs. Smith that she is "selfish" for wanting to remain at home and "spend all her money on herself," and she asks you to "put some sense into Mom's head" because she does not want to visit every day when she has a "perfectly nice room" that Mrs. Smith can use. With your support, Mrs. Smith is able to express her strong desire to remain home and to have her daughter visit each day to help her at home. However, she will not tell Linda about her fears of Linda's husband or talk about the pressure that Linda has put on her to sell the house.

You have some concerns about the amount of support Mrs. Smith will need to remain in her home; however, you are also concerned about the potential for financial exploitation and abuse if she moves in with her daughter. While you would like to more directly address the issue of potential financial exploitation, as long as Mrs. Smith has the capacity to make decisions, you must respect her choice to remain silent on the issue.

Geriatric Assessment

Overview

In working with a vulnerable adult, it is important to recognize the possibility for abuse, neglect, and exploitation and to determine whether elder abuse has occurred. Then possible interventions can be explored: intervention examples will be highlighted later in this module. A thorough geriatric assessment tool can help identify risk factors related to abuse. Students should discuss the guidelines below in conjunction with examples from case studies of older adults for whom abuse, neglect, or exploitation has been identified (such as the case studies provided). Students could also consider how they would acquire the information needed about the woman in the NYCEAC video clip referenced above.

A geriatric assessment expands the focus of the generalist biopsychosocial assessment framework to focus on the unique strengths, limitations, and potential risks of the older adult. The following assessment guidelines are adapted from Chapter 4 of *Social Work with Older Adults* by Katherine McInnis-Dittrich (2014).

When assessing older adults, social workers must keep in mind that:

- Older adults are a very heterogeneous group, thus assessment processes must respond to the unique characteristics of each client.

- Social workers must recognize that the fear of losing autonomy may lead an older adult to minimize functional limitations.
- Often, older adults do not initiate requests for assistance, when evaluating a referral, consider these questions:
  - Who referred the client (self-referral, family, friend, organization/agency, anonymous)?
  - Whose goals will be addressed by the assessment?
  - Why was the client referred?

The goal of the assessment is to identify the client's strengths and limitations and to assist him/her in creating, reviewing, and implementing options/interventions.

Confidentiality is a key component in building the trust relationship that must be fostered from the beginning stage of assessment. If possible, conduct the assessment in the older adult's environment. It increases the comfort level of the client and gives the social worker vital information as to how the individual functions. Much of what a social worker learns about the client results from viewing his or her physical abilities, environment, and behavior.

The assessment process can take several hours and multiple visits. With an abused older adult, the process of establishing trust may take longer. The social worker in normal circumstances should make appointments to assess the client; but in suspected elder abuse cases, unannounced visits are sometimes necessary to verify the safety and stability of the client's environment.

The client may want the presence of friends or family during the initial meeting, but their presence should be avoided if possible for privacy and confidentiality purposes. For instance, the client may be hesitant to disclose personal information in the presence of others. In a situation where abuse is suspected the social worker should interview the abused client without the presence of his/her caregiver, family, or suspected abuser. The social worker must be cognizant of the difficult position an abused elder is in when living with or dependent on an abuser. Often a sense of powerlessness portrayed by the elder is an indicator of abuse.

If the presence of others is necessary, have the client sit across from the social worker with the other individuals sitting behind and out of the client's line of sight. This will prevent the individuals present from cueing the client, and can help the social worker determine the level of dependency and the level of support received by the client.

As described in Module I, there are many factors that may prevent the abused or neglected elder from reporting abuse or denying its occurrence. Factors include shame, guilt, fear, or hopelessness. The abused elder may have a fear of being abandoned or being placed in a facility if there is an allegation of abuse. The elder may also be afraid of retaliation by the abuser.

When conducting the interview, establishing rapport is vital. Allow the older person to talk at his/her own pace, without interruption. Much of the information a social worker needs for the assessment is often disclosed in the stories of the client's life. It is also necessary to establish and maintain a rapport with the client's immediate support system. In the case of the abused elder this may include the abuser. This can be personally challenging for the social worker but is frequently vital to the continued safety of the client.

If the caregiver is the suspected abuser, it is important to frame the questions around the client and his/her situation so as not to provoke the suspected abuser. It is essential to assess the degree to which the suspected abuser is dependent on the client as well as the family dynamics

of finances and power. Does the client financially support the suspected abuser? Is the client a financial burden for the suspected abuser? Perpetrators of abuse often have substance abuse issues or unmet financial needs. For a list of risk factors for financial abuse, visit http://www.preventelderabuse.org/elderabuse/fin_abuse.html.

The social worker will need the consent of the client to reveal confidential information (social security number, address, phone numbers, birth date) that is necessary to receive benefits (e.g., Medicare, Social Security, Medicaid). The client must be informed of the circumstances under which confidentiality is waived. The client should also be notified if action is to be taken in the event of a disclosure of harm to self or others, child abuse, or elder abuse. It may be difficult to advise the client of such actions, but it is vital to preserving the trust relationship. The social worker is obligated to fully inform the client of his/her rights, the extent of the agency's services, and the responsibilities of the social worker to the client.

Assessment Components

The level of assessment detail will vary depending on the setting in which the social worker is working. The information below is typically collected in a comprehensive assessment. Links to assessment tools and other information are included throughout this section.

McInnis-Dittrich (2014) suggested that social workers can gain a lot of information by asking the client about a typical day. This way, the social worker can more naturally ask questions about who helps the client in carrying out day-to-day activities and can pick up cues about how well the older adult is being treated by family members, friends, and other caregivers. While conducting an assessment, social workers must keep in mind the risk factors for elder abuse (listed in Module 1).

Client Information:

- Age: Requirement for eligibility for services/resources
- Marital Status: Single, married, widowed, divorced, partnered; possible eligibility for spousal benefits, such as Social Security or pension
- Education: Highest grade completed, language comprehension, ability to read and write
- History: Birthplace, childhood home, family members, social roles, work history, important historic events, significant people past and present, deaths

Functioning:

- Is the client independent or in need assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)?
  - o ADLs are basic self-care tasks: bathing, dressing, toileting, transferring, and self-feeding. Example assessment form: http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf.
  - o IADLs relate to maintenance of an independent household: transportation, shopping, preparation of meals, housework, money management, medication management, and use of telephone. Example assessment form: http://consultgerirn.org/uploads/File/trythis/try_this_23.pdf.

- Who assists the client with functioning needs? For example, does the client drive, have access to public transportation (bus or light rail), or have access to transport or taxi services? Do relatives or friends help with transportation needs?
- Does the client use assistive devices (e.g., wheelchair, cane, or walker)?

Legal:

Factors such as a lack of familiarly with finances, social isolation, cognitive impairment, and a recent loss of a loved one can increase an older adult's risk of financial abuse. In addition to these characteristics, social workers should collect the following information:

- Person(s) in charge of the older person's financial affairs.
- Eligibility for linkage to services, such as Medicaid or home and community-based services, and services currently in place.
- Whether the older person has a durable power of attorney for financial affairs and health care decision-making and advanced directives of any kind. Establish who has been named to make decisions when the older person is no longer capable.

In relation to advance directives, determine if the client made any decisions regarding medical intervention, where they want to die (at home, hospice, hospital), and who is designated to carry out the client's wishes. These issues are important to discuss with any adult client. (For more information about advanced directives, visit the National Hospice and Palliative Care website: http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3285.)

Physical Environment:

Social workers can learn a lot about the client and the client's abilities from the organization of the living space. For example, falls can lead to injuries such as hip fractures, which in turn can lead to decline in physical and mental well-being. As discussed in Module 1, a decrease in mobility can lead to an increased risk of abuse. As a part of your assessment, you are looking for potential risks for falls such as throw rugs on the floor. Other questions to consider: Has the client reduced or miniaturized the surrounding living space to incorporate a lack of mobility? Has the bedroom been moved into the living room to maintain control over household tasks? On the other hand, the bedroom may have been moved for the convenience of the caregiver. The physical location of the client within his or her home may indicate risk for abuse, neglect, or self-neglect. Is there a calendar on the wall and is it current? Is there a clock and is it set to the proper time? Is there the scent of urine or are there urine stains?

Social Supports:

Inadequate social support and social isolation are risk factors for abuse, neglect, and exploitation. It is very important to get a sense of who is in the older adult's social network. The social worker should ask about:

- Quality and frequency of contacts/events: Has there been a decline recently?
- Family, companions, friends, neighbors, religious organization, clubs, senior center.
- Instrumental supports (formal and informal caregivers).
- Social roles (grandparent, volunteer, mentor).
- Employment (full or part-time, what type of work, self-satisfaction, financial need).

- Activities, hobbies, sports/entertainment (golf, bingo, movies).
- Where or from whom does the client seek comfort?
- Who would the client call in the event of an emergency besides 911?

One tool used to assess social support is the Lubben Social Network Scale, which was developed by Dr. Jim Lubben, social worker and professor at Boston College. More information is available here: http://www.bc.edu/schools/gssw/lubben.html.

Physical Health:

The assessment of issues related to physical and psychological health is important because of the interconnection between health and other aspects of well-being. The following are a few examples of topics that social workers would cover as part of a physical health assessment; the list is not exhaustive. The older adult's answers to these questions can alert the social worker to possible abuse, neglect, or self-neglect. Some of the topics – such as incontinence – are sensitive. It may be helpful to bring up the subject by saying "Many people your age experience ____."

- Self-rating of health: The older person's opinion on his or her health gives the social worker insight into how she/he has adapted to chronic conditions and a chance to determine whether what is being reported is consistent with what is observed.

- Medical history: What are current and past medical problems? What injuries and hospitalizations have occurred? Has the older adult needed to go the emergency room? For what and how frequently? Is there a primary care physician? Some of this history will help the social worker gain a sense of whether there are unexplained injuries or whether the older adult or his or her caregiver is neglecting the need for regular medical care.

- Medication use: The social worker needs to assess for correct and regular usage of prescribed medications. The use of multiple medications leads to the potential for interactions that may be detrimental. Because of expense, older adults may cut their dosage or let prescriptions lapse. Caregivers may neglect to administer medication as needed.

- Incontinence: Many older adults are embarrassed to discuss this issue, but managing bladder and bowel functions is essential to the maintenance of independent living. For example, if the older adult is incontinent and unable to clean herself, skin breakdown can occur. If a caregiver neglects to properly assist the older adult, physical and psychological harm can result. The social worker can act as an advocate in helping the older adult to understand that incontinence is not an inevitable part of the aging process and can be treated (McInniss-Dittrich, 2014).

- Use of alcohol and other substances: Ask about current and past use. Do not assume that older adults do not use recreational drugs. When assessing alcohol use, be specific about type of alcohol (e.g., beer, wine) and quantity (a "glass" can be anywhere from 4 to 20 ounces and "a few beers" can be an entire six-pack). Alcohol and drug abuse can contribute to poor health and loss of functioning in the older adult, and it has been linked to self-neglect (Spensley, 2008).

- Nutrition, diet, and exercise: Adequate nutrition and exercise are important in maintaining physical and psychological health. Find out how often the older adult eats and what the diet consists of. Many factors can contribute to loss of interest in food, such as medications, poorly fitting dentures, and loneliness.

Psychological Health:

The National Center on Elder Abuse (NCEA) reports that older adults living with dementia are at a greater risk for abuse than those without. A 2009 study found that almost 50% of adults with dementia experience some form of abuse (Cooper et al., 2009). Another study (Wiglesworth et al., 2010) concluded that 47% of participants with dementia were abused by their caregivers. Social workers should assess the caregiver's mental and emotional status as well as the availability of support.

Examples of information typically collected include:

- Personality: Determine how the older adult views the world and how he/she copes with stress
- Cognition or mental status: While not appropriate for all older adults, the Mini Mental State Examination (MMSE) is commonly used; many forms are available for download. (For an example, see http://www.mountsinai.on.ca/care/psych/on-call-resources/on-call-resources/mmse.pdf.)
- Emotional well-being: Signs of possible depression include lost of interest in previous activities; weight loss; changes in appetite or sleeping patterns; irritability; feelings of hopelessness, sadness, or uselessness; and thoughts of suicide. Many older adults exhibit anxious behaviors as well, but a relatively small percentage has full-blown anxiety disorders, so careful assessment of symptoms is important.

Because older adults as a group are at a higher risk for cognitive impairment, it is essential social workers perform a capacity assessment (see the Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists, APA, 2008).

Capacity Assessment

The next step in determining the need for an intervention is to evaluate the client's cognitive functioning (Gibson & Qualls, 2012). An important ethical dilemma social workers face in working with older clients involves identifying whether an individual is competent to make informed decisions. Thus, social workers must have the skills and knowledge to address many vital questions. How is competency determined? And if the client is competent when do threats to safety outweigh the client's right to self-determination? Each situation a social worker encounters will be unique, and there are no set answers to how to handle a specific situation.

One of the problems that social workers encounter is in identifying factors that affect a client's capacity to make decisions and knowing how a client demonstrates the ability to make informed decisions.

Assessing capacity is particularly relevant to working with older adults for the following reasons:

- Chronologic age is one of the chief risk factors for developing cognitive and physical impairments.
- Cognitive and physical impairments can affect a person's ability to perform IADLs.
- Cognitive and physical impairments can put a person at risk for abuse and exploitation.
- Social workers are ethically bound to protect their clients to the extent legally possible.

Therefore, social workers must understand the concepts of autonomy, decisional capacity and incapacity, and basic elements of capacity assessment. Social workers must recognize when a capacity assessment is needed.

- **Autonomy** is the right to make one's own decisions. Understanding the concept of autonomy is essential when working with older adults, because of our ethical responsibility to honor and protect self-determination whenever possible.
- **Decisional capacity** is the ability to adequately process information in order to make a decision based on that information. Capacity may vary due to stress and the complexity of the decision. It may also vary depending on the day or time of day. A full capacity evaluation includes a physical and neurological exam, a short- and long-term memory assessment, assessment of executive function, and examination of psychological disorders along with diagnosis of addictions.
  - **Executive function** is a set of abilities that control and regulate a person's ability to anticipate outcomes and adapt behavior to changing situations.
- **Incapacity** is the inability to receive and evaluate information OR to make or communicate decisions to such an extent that the individual cannot meet essential requirements for physical health, safety, or self-care. It is important to distinguish between legal incapacity, which is a judgment about one's legal rights and responsibilities, and clinical incapacity, which is a judgment of one's functional abilities.
  - **It is not easy to determine incapacity.** Many things can affect it, such as medication interactions, substance abuse, and mental illness. The social setting and nutrition can also affect it.
  - **The implications of being judged as incapacitated are life changing.** For example, a client may lose the right to make her/his own decisions about medical treatment and personal care – or where they want to live. Have students discuss the implications for being judged incapacitated in this area and in the area of relationships (e.g., having sex), forming contracts, making a will, and participating in research.

Capacity Assessment – Four Basic Questions:

When doing a capacity assessment, social workers are assessing the client's ability to understand and follow instructions, understand risks and benefits, and make and execute a plan. Capacity assessment requires skill and training, and social workers should always consult supervisors to determine if referral to an expert is necessary.

Four basic questions a social worker can ask to assess capacity are:

- Can the client understand relevant information?
  Have students provide an example.
- What is the quality of the client's thinking process?
  Have students provide an example of how they would assess this process.
- Is the client able to demonstrate and communicate a choice?
  Provide students with an example.
- Does the client appreciate the nature of his/her own situation?
  Have students discuss what questions should be asked to determine if the client understands the situation?

Handouts and case examples for capacity assessment can be found at
http://theacademy.sdsu.edu/mastertraining/client-decision-making-and-capacity-for-aps-pg/.

Elder Abuse Screening Instruments

When conducting an assessment, social workers need to be aware of the signs that elder abuse might be taking place (Module 1 covers risk factors for elder abuse, neglect, and exploitation). Identifying potential signs of abuse and not mistaking those signs for "normal" aging is critical. Unexplained injuries or bruises, depression, fearfulness, changes in appetite, sudden changes in behavior, and sleeplessness are indications that the social worker should probe more directly about potential elder abuse and neglect. A number of screening instruments have been developed for use in different settings. Screening instruments do not diagnose elder abuse but a positive screen means that a more thorough assessment should be completed and/or that referral to APS is warranted.

The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) is one useful tool. This instrument contains 15 items that examine three categories of abuse including overt violation of personal rights or direct abuse, characteristics of the older adult that make him or her susceptible to abuse, and characteristics of situations that might lead to abuse (Anthony, Lehning, Austin, & Peck, 2009).

An example of a longer screening instrument that is used in clinical settings is the Elder Assessment Instrument (EAI). This 41-item assessment instrument takes 12-15 minutes to complete; it assesses signs, symptoms, and subjective complaints of physical abuse, neglect, exploitation, and abandonment. Major strengths of the instrument include its rapid assessment capacity and the way it sensitizes health care providers to screen for abuse. One limitation to note is that it does not result in a score (Fulmer, 2012).
See Anthony et al. (2009) for a review of screening instruments.

Elder Abuse Prevention and Intervention

Elder justice was identified as a top priority at the 2015 White House Conference on Aging (WHCoA) because of the increasing size and scope of elder mistreatment. The following action items were identified based on available data from the Elder Justice Roadmap Project (U.S. Department of Justice and Department of Health and Human Resources, 2014): developing a knowledge base for elder mistreatment, implementing a coordinated policy approach to address abuse, and creating an integrated network of elder mistreatment services and training opportunities. Attention to these key items will improve efforts to prevent and treat elder abuse, neglect, and exploitation. Review the 2015 WHCoA issue brief on elder mistreatment for a list of research, direct services, and policy recommendations (Pillemer, Connolly, Breckman, Spreng, & Lachs, 2015).

The table below provides information about initiatives that are raising awareness about elder abuse and increasing the training and resources available to care for victims.

Initiative	Description
Elder Justice Roadmap Project	Solicited input from experts and stakeholders in order to develop a strategic resource—by the field and for the field—to combat elder mistreatment. http://www.justice.gov/elderjustice/research/resources/EJRP_Roadmap.pdf
The Elder Abuse and Neglect Initiative	Launched in 2005 with funding from the Archstone Foundation, this California statewide effort collected and disseminated best practices related to elder mistreatment. http://archstone.org/docs/resources/ElderAbuse_5YrReport_Final_090711.pdf
The Harry & Jeannette Weinberg Center for Elder Abuse Prevention	The Center, which includes an emergency elder abuse shelter, was established at a nonprofit nursing home in New York City. The Center not only provides emergency shelter services, but also coordinates crisis intervention and training opportunities. This model has been replicated at seven nonprofit organizations. http://www.riverspringhealth.org/elder-abuse-shelter.aspx

"The goal for elder abuse prevention is simple: to stop it from happening in the first place. However, the solutions are as complex as the problem" (Centers for Disease Control, 2014). Stark (2012) discussed several strategies for increasing the public's awareness of elder abuse, which include continuing education opportunities for health professionals and more community-based education programs. NCEA's Innovative Practices Database provides a national collection of program models and resources related to elder abuse prevention and intervention. More information can be found here: http://www.ncea.aoa.gov/Stop_Abuse/EBP/Database/index.aspx.

Adult Protective Services and Mandatory Reporting

This section provides a useful overview of Adult Protective Services (APS) philosophy, ethical guidelines, and core activities. The National Adult Protective Services Program (NAPSA) has developed recommendations for minimum program standards for APS (http://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf).

APS responds to elder abuse that takes place in community settings in all states and responds to institution-based elder mistreatment in some states. APS uses intervention models such as case management, crisis intervention, and guardianships, and other involuntary services including removal to a hospital or skilled nursing facility. Most APS agencies deal with situations involving at-risk older adults (usually age 65 or older) or dependent adults aged 18-64 who have physical and/or mental impairments. There are no federal laws or policies that direct how protective services should be delivered, and state statutes differ in terms of the definitions of abuse and what types of abuse are covered (Brandl et al., 2006). The situations of clients that APS workers encounter can be very complex and fraught with ethical dilemmas.

Most state elder abuse mandatory reporting systems are based on the premise that older adults need protection by the state if they are being harmed by others, are unwilling to accept services, and meet some pre-determined criteria for diminished capacity to make informed decisions on their own behalf. Good assessment skills are necessary for APS workers because they also serve as investigators who are called upon to collect evidence that may be used to prosecute perpetrators. Bringing these cases to justice is difficult. One barrier is that older adult victims may not want to see the perpetrator, who is often an adult child, prosecuted, though they would like the perpetrator to receive help. APS workers have also expressed concern that in some

types of cases, such as neglect, the involvement of law enforcement may do more harm than good.

In most states, social workers are legally mandated to report suspected elder mistreatment, including self-neglect. The case study below provides an example of self-neglect. Social workers may find that older adults are reluctant to report mistreatment or neglect or accept help because they fear losing their independence or the relationship with the abuser. In general social workers need to be aware that there is no simple answer to the question of whether mandatory reporting will benefit or harm the elder victim overall. The National Coalition on Abuse in Later Life has materials that help address the difficulties associated with mandatory reporting (http://www.ncall.us/content/mr).

Most mandatory reporting laws have provisions that provide for the confidentiality and protection of the reporter against liability. Social workers need to familiarize themselves with the reporting laws in their states. Reports may be submitted anonymously in some states. According to the National Adult Protective Services Association, a person who makes a good-faith report of suspected abuse and neglect has the right to confidentiality of his or her identity, protection from civil and criminal liability and professional disciplinary action, protection for providing the information related to a report of suspected elder abuse, and protection against retaliation by an employer. More information can be found here: http://www.napsa-now.org/get-help/confidentiality-safety/.

Assessment and Intervention in Adult Protective Services — A Case Study

One of the most important factors in the assessment process is the ability to establish a trusting relationship, and developing this trust is vital in cases of self-neglect, which are the most common ones. There are many factors that inhibit the process of the trust relationship with older adult clients. Some of the factors include the elder's history, culture, shame, and fear, as exemplified by the case of Mr. Y.

Mr. Y is a Japanese American elder who was reported to APS (by an undisclosed source) for self-neglect. During WWII, Mr. Y was placed in an internment camp and lost all of his property. As a result of this experience, he is mistrustful of any interventions by outsiders. A social worker must be aware of how prior events in the client's life can counter or deter efforts to engage the client in obtaining needed services.

From a cultural perspective, the oldest male of the Japanese family is traditionally the head of the family, and his daughters or daughters-in-law would be obligated to take care of him. There has long been the assumption that the older adult would and should be taken care of by his or her family. Many cultures, including American society, hold this belief, which is supported by government policies. The reality is that the nuclear and extended family no longer lives in one local together. Long-distance relatives or caregivers are often unaware of the condition (physical, mental, or financial) of the older adult or of the condition of the living quarters. Along with this changing dynamics of family relationships, Mr. Y may have underlying feelings of shame that he needs help or that he will become a burden. Or he may feel that he is doing fine and doesn't need any assistance.

Another key factor in older adults' resistance to outside interventions is the pervasive fear of being institutionalized and forgotten. They fear losing control over decision-making and losing independence, along with the fear and shame associated with admitting dependency.

One of the things a social worker can do to open a line of communication with the resistant or involuntary client is to acknowledge the rights of the client. The client has a right to refuse services. It is equally important for the client to recognize that there are, on occasion, consequences associated with refusing services. In the case of Mr. Y, his home was deemed a fire hazard, and he was ordered to comply with city health and safety codes or be evicted. Mr. Y understood that his home needed to be cleaned and maintained but saw this official order as another attempt by government to take his property.

This case shows how important it is to start where the client is. The client's fear or trust issues may make several attempts necessary to gain his/her confidence. Be respectful of the client and empathetic to the client's situation. Acknowledge the client's apprehensions about accepting assistance and help the client understand the social worker's role. Remind the client that the her/his safety is the primary concern and that the social worker's is there to assist in maintaining independence to the extent possible in a safe manner.

A social worker must be aware of the eligibility requirements and the resources available that may assist the client in maintaining his/her independence. Mr. Y eventually consented to allow the social worker to obtain funding for housekeeping services to ensure that his home would continue to meet city regulations. The social worker also successfully negotiated on the client's behalf to suspend the fines levied by the city for code violations.

Guardianship

Individuals need guardians when they no longer have the capacity to make decisions for themselves. Thus, there are times, when for the safety of the client, it is necessary to seek intervention by the family for guardianship/conservatorship or from the Office of Public Guardian due to the diminished capacity of the client. Different types of guardianship are used, depending upon the needs of the client. A conservator, or "guardian of the estate," makes decisions related to finances whereas a "guardian of the person" makes non-financial decisions. Some guardians fulfill both roles. Generally, there are three categories of guardians: (1) family member or someone known to the individual; (2) professionals, often attorneys, who serve as guardians for individuals who have sufficient financial resources; (3) public guardians, who are provided by many states for adults who lack both resources and family or friends available to serve as their guardian.

Because establishing guardianship reduces a person to the legal status of a minor and permanently takes away his or her rights to make decisions related to finances, health care, and living arrangements, any effort to seek guardianship raises legitimate concerns and highlights the ethical dilemma of self-determination versus protection of older adults. General concerns about guardianship include challenges in determining legal standards for incompetence and incapacity, concerns that those protected are family members rather than the person needing guardianship, and insufficient oversight of the system by the courts. In general, advocates for older adults see guardianship as a last resort process and that other, less restrictive, options should be exhausted first (O'Sullivan, Rowthorn, & Callegary, 2011).

Relocation and Placement in Institutions

If the family is motivated to have the older adult move-in with them, the social worker involved should fully discuss possible changes in the dynamics of the caregiving family. It is also important to know the history of family interactions. Is this a safe environment for the older

adult? Has there been a history of violence or abuse within the family? What is the motivation for the caregiving family? Is it finances? Are there resources that can assist the older adult and family in making the transition?

It may become necessary to assist the client with placement into an independent living retirement facility; skilled nursing home; assisted living, adult family home; or other institutional setting. Such a massive transition involves numerous losses for an older adult, who is often faced with leaving a home filled with memories and possessions for a single room or in some circumstances a double with a roommate. The older adult often has to leave the neighborhood he/she is familiar with and his/her friends and neighbors. He/she may also have to leave a beloved pet. The elder often has to change his/her daily routine or diet. Change is difficult for the most motivated client. For the involuntary client it can be traumatic, and for the social worker it can be emotionally challenging.

Multidisciplinary Teams in Adult Protection

A variety of collaborative efforts and team approaches exist for addressing mistreatment. Elder abuse forensic centers provide multidisciplinary expertise to aid in the resolution of complex cases. One example is the Los Angeles County Elder Abuse Forensic Center, which hosts a multidisciplinary team consisting of a geriatrician and representatives of APS, the police, the district attorney, the office of the public guardian, and other professionals such as a forensic neuropsychologist. APS workers may refer hard to resolve or complex cases to the forensic center, and research has shown that involvement by the center has increased the prosecution of cases of financial exploitation (Navarro, Gassoumis, & Wilber, 2013). Another example is Financial Abuse Specialist Teams that have been set up in a number of communities. These multidisciplinary teams focus on financial exploitation (http://www.ncea.aoa.gov/Stop_Abuse/Teams/FAST/index.aspx).

The Family Care Conference model, which involves a structured family meeting attended by the older person, family members, and involved agencies, has been piloted in several Native American communities (Holkup, Salois, Tripp-Reimer, & Weinert, 2007). The goal of the meeting is to develop a plan that will provide for the protection of the older adult while meeting the needs and desires of the family unit.

Legal teams have been established in order to improve the ability to bring perpetrators to justice. Police officers work with victim advocates within the domestic violence realm. Fatality review teams assist in identifying forensic markers for elder mistreatment. Strategies that would promote victim advocacy and supports for local, state, and federal prosecutors in their efforts to detect, investigate, and prosecute elder abuse are also needed.

The social worker's role in a multidisciplinary team will depend upon her/his particular role on the team and the function of the team.

Summary

Social work values and ethics inform our interactions with older adults, and social workers may be particularly challenged in upholding values such as self-determination and respect for autonomy when abuse or neglect is an issue. This module provides an overview of information typically collected during assessment of older adults. Because research tells us that at least 10% of all older adults may be victims of abuse and neglect, social workers who work with older

adults must keep the potential for abuse and neglect in mind when they assess these clients. In particular, social workers must understand principles of capacity assessment and recognize the need for supervision and consultation with challenging cases. Social workers must report suspected elder abuse and neglect to APS. The range of responses may include provision of resources, relocation to an institution, or guardianship. Multidisciplinary teams exist in many communities to address complex cases of elder abuse that require expertise from medical, legal, and social services professionals. All social workers need to recognize possible signs of abuse and neglect and be knowledgeable about the resources available to assist older adults and their families.

<center>**Resources**</center>

Books

McInnis-Dittrich, K. (2014). *Social Work with Older Adults (4th ed.)*. Boston: Pearson. Chapters 4-6 on assessment; Chapter 11 entitled "Social Work Practice in Identifying and Preventing Abuse and Neglect of Older Adults."

Nerenberg, Lisa. (2008). *Elder abuse prevention: Emerging trends and promising strategies*. New York: Springer.

Helpful descriptions of different approaches to elder abuse prevention including APS, domestic violence, and criminal justice service settings. Describes ways in which communities, agencies, and national organizations have organized to prevent and ameliorate elder abuse through cooperation and team approaches.

Training Materials On-Line

Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists, APA, 2008
http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf

National APS Resource Center: Core APS Competencies Training
http://www.napsa-now.org/resource-center/training/core-aps-competencies/

This link will take you to a 23-session core curriculum around practice issues in Adult Protective Services known as Project MASTER. All the modules that are labeled "instructor-led" under "Type of Training" include scripted materials, learning activities, and PowerPoint Presentations that instructors may adapt for classroom use. The Project MASTER website (http://theacademy.sdsu.edu/programs/Project_Master/core.html) provides the direct link.

The Field Guide for APS outlines 19 Knowledge Areas identified as necessary for APS work and is designed for the training of APS workers. Many of the materials are suitable for use when teaching social work students about identifying and responding to elder abuse in the community. It includes handouts, case examples, and assignment descriptions. (http://theacademy.sdsu.edu/programs/Project_Master/handouts/Field_Guide_for_APS_Ver1.pdf)

The module on capacity assessment is helpful for teaching how to identify whether clients have the ability to make informed decisions.
http://theacademy.sdsu.edu/programs/Project_Master/client_capacity.html

National Coalition of Abuse in Later Life (NCALL)

Walk in Our Shoes: Working with Older Survivors of Abuse – Video and Training Guide

http://ncall.us/content/walk-in-our-shoes

This link takes you to video segments and a discussion guide that are designed to encourage critical thinking and discussion about the services set up to meet the particular needs of older adults who are victims of abuse in later life. These materials are valuable in that they help students consider the older adults who are not care-dependent, yet who may have experienced long-term spousal abuse or abuse from family members such as adult children. The videos offer examples of services, viewpoints from various service providers, and the voices of survivors of abuse in later life.

Annotated Bibliography – Practice Resources

Anthony, E. K., Lehning, A. J., Austin, M. J., & Peck, M. D. (2009). Assessing elder mistreatment: instrument development and implications for adult protective services. *Journal of Gerontological Social Work, 52*(8), 815-836. [doi: 10.1080/01634370902918597]

Reviews why it is difficult to define, identify, and document elder abuse. Reviews standardized assessment instruments and protocols to respond to the need to provide structure for assessment process in APS and other settings.

Bergeron, L. R. (2006). Self-determination and elder abuse: Do we know enough? *Journal of Gerontological Social Work, 46*(3/4), 81-102.

This thought-provoking article draws upon the author's clinical experience to highlight situations where social workers may mistakenly invoke the principle of self-determination to the detriment of clients. Contains a helpful discussion about assessing capacity when clients are ill, in crisis, depressed, or socially isolated.

Chihowski, K., & Hughes, S. (2008). Clinical issues in responding to alleged elder sexual abuse. *Journal of Elder Abuse & Neglect*, *20*(4), 377-400. doi: 10.1080/08946560802359383

With case examples, illustrates issues that workers may encounter, including ill-timed diagnostic evaluations, distinguishing consenting marital relations from sexual abuse, the victim's desire to protect the perpetrator, and the reluctance of health care practitioners to conduct examinations for rape and sexual assault. Also addresses sexual abuse in assisted-living facilities.

Cramer, E. P., & Brady, S. R. (2013). Competing values in serving older and vulnerable adults: Adult protective services, mandated reporting and domestic violence programs. *Journal of Elder Abuse & Neglect, 25*, 453-468. [doi: 10.1080/08946566.2013.782781]

Provides a conceptual framework to explain differing service philosophies and approaches used by APS and domestic violence programs, particularly over client self-determination. Recommends that programs collaborate through getting to know and understand the work of each other and developing protocols to work together.

Dayton, C. (2005). Elder Abuse: The Social Worker's Perspective. *Clinical Gerontologist, 28*(1-2), 135-155. doi: 10.1300/J018v28n01_07

This article was a part of a special issue of this journal on the clinical management of elder abuse. It uses case studies to illustrate social work intervention in a case of self-neglect, abuse by a caregiver previously abused by the victim, and a grandmother with dementia cared for by young grandchildren.

Jackson, S. L., & Hafemeister, T. L. (2011). Risk factors associated with elder abuse: The importance of differentiating by type of maltreatment. *Violence and Victims, 26*, 738-757. [doi: 10.189/0886-6708.26.6.738

Used both administrative data and interviews with APS caseworkers and elderly victims (or their guardians if incapacitated) to examine factors distinguishing four types of elder maltreatment - pure financial exploitation, physical abuse, neglect by others, and hybrid financial exploitation. Hybrid financial exploitation is the combination of financial exploitation with either physical abuse or neglect by others. The dynamics of hybrid financial exploitation are different from those of "pure" financial exploitation, which often involves non-family members and relative strangers in situations such as consumer fraud.

Liao, S., Kumari M. J., Bufalini, E., & Wiglesworth, A. (2009). Elder mistreatment reporting: Differences in the threshold of reporting between hospice and palliative care professionals and adult protective service. *Journal of Palliative Medicine, 12*, 64-70. [doi: 10.1089/jpm.2008.0173]

When compared with APS workers, hospice and palliative care workers were less likely to rate vignettes describing elder abuse as "reportable."   An example of research that highlights inter-professional differences in recognition and reporting of elder abuse.

Otto, J. M. (2000). The Role of Adult Protective Services in Addressing Abuse. *Generations, 24*(2), 33-38.

Helpful brief article that explains the origins and structures of APS in the United States. Discusses how interest in addressing elder abuse and neglect became connected with APS practice in spite of the fact that APS responds to abuse and neglect of vulnerable younger adults as well.

Works Cited

Anthony, E.K., Lehning, A.J., Austin, M.J., & Peck, M.D. (2009). Assessing elder mistreatment: Instrument development and implications for adult protective services. *Journal of Gerontological Social Work, 52*(8), 815-836. doi: 915858527 [pii]10.1080/01634370902918597

Brandl, B., Dyer, C.B., Heisler, C.J., Otto, J.M., Stiegel, L.A., & Thomas, R.W. (2006). *Elder abuse detection and intervention: A collaborative approach*. New York: Springer Publishing Company.

Centers for Disease Control and Prevention. (2014) Elder Abuse: Prevention Strategies. Retrieved from http://www.cdc.gov/violenceprevention/elderabuse/prevention.html

Cooper, C, Selwood, A,, Blanchard, M., Walker, Z., Blizard, R., & Livingston, G. (2009). Abuse of people with dementia by family carers: Representative cross sectional survey. *British Medical Journal*, *338*, b155

Fulmer, (2012). Elder Mistreatment Assessment. *Try this: Best practices in nursing care to older adults.* Retrieved from http://consultgerirn.org/uploads/File/trythis/try_this_15.pdf

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

Holkup, P.A., Salois, E.M., Tripp-Reimer, T., & Weinert, C. (2007). Drawing on wisdom from the past: An elder abuse intervention with tribal communities. *The Gerontologist, 47*, 248-254.

National Hospice and Palliative Care. (2015). Advance Care Planning: Advanced Diretives. Retrieved from http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3285

Navarro, A.E., Gassoumis, Z.D., & Wilber, K.H. (2013). Holding abusers accountable: An elder abuse forensic center increases criminal prosecution of financial exploitation. *The Gerontologist, 53*(2), 303-312. doi: 10.1093/geront/gns075

O'Sullivan, J., Rowthorn, V., & Callegary, E.A. (2011). Guardianship and its alternatives: A handbook on Maryland law.   Retrieved April 30, 2012, from http://www.aging.maryland.gov/documents/GuardianshipHandbookRevised2011.pdf

Pillemer K., Connolly, M. T., Breckman, R., Spreng, N., & Lachs, M.S. (2015). Elder mistreatment: priorities for consideration by the white house conference on aging. G*erontologist, 55*(2), 320-327.

Spensley, C. (2008). The role of social isolation of elders in recidivism of self-neglect cases at San Francisco Adult Protective Services. *Journal of Elder Abuse & Neglect, 20*(1), 43-61. doi: 10.1300/J084v20n01_03

Stark, S. (2012). Elder abuse: Screening, intervention, and prevention. *Nursing, 42*(10), 24–29. http://journals.lww.com/nursing/Fulltext/2012/10000/Elder_abuse__Screening,_intervention,_and.10.aspx#

Wiglesworth A, Mosqueda L, Mulnard R, Liao S, Gibbs L, & Fitzgerald W. (2010). Screening for abuse and neglect of people with dementia. *Journal of the American Geriatrics Society, 58*(3), 493-500.

Elder Justice Module 3:
Elder Justice Policy

Competencies Addressed

- Engage in policy practice

Objectives

1. To promote the empowerment of older adults
2. To provide an overview of existing federal programs assisting older adults, with emphasis on programs related to elder justice
3. To gain a broader perspective of policy issues related to elder justice
4. To understand the interconnection between policies for older adults and policies for adults with disabilities

Introduction

According to the Elder Justice Act, from a societal perspective elder justice involves efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and to protect elders with diminished capacity while maximizing their autonomy. From an individual perspective, elder justice requires the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

Although elder justice may seem like an elusive goal, social workers and other advocates have seen progress in improving the federal response to elder abuse (Blancato, 2012). Social workers understand how social policies respond to societal needs and that they have an impact on our lives and our future. Social workers are on the front line of every social problem, including the abuse, neglect, and exploitation of older adults. They see needs, gaps in services, and the effects that social policies have on the well-being of older adults. Social workers have an opportunity to provide leadership and an ethical obligation to work towards change. The burgeoning population of older adults demands that policy makers respond to their needs. Policies regarding protection, caregiving, and mental health issues of older adults are evolving and changing. This is an opportune time to evaluate past and present policies and to provide leadership that will guide the policies of our future. It is noteworthy that elder justice is one of four policy areas highlighted in the 2015 White House Conference on Aging (Kaplan & Pillemer, 2015). It was announced during the conference that the Victims of Crime Act assistance guidelines will be updated to reflect how the funds may be used to support social and legal services to underserved victims, including older victims of abuse.

Furthermore, the Assistant Secretary for Aging has made elder justice her top priority for the Administration on Aging (AoA) and the Administration for Community Living (ACL). The Elder Justice policy brief summarizes federal efforts to address elder abuse (http://www.whitehouseconferenceonaging.gov/blog/policy/post/elder-justice-policy-brief).

This module provides an overview of major federal programs for older adults and their connections with elder justice issues, including programs authorized by the Older Americans Act (OAA). It describes how the Americans with Disabilities Act (ADA) and the Supreme Court's decision in the Olmstead case have changed the ways services are provided for adults with

disabilities and older adults (Milne, 2012) and considers the implications for elder justice. It provides resources for teaching about the Elder Justice Act (EJA), the first major federal legislation to address elder abuse and neglect on a national scale. It also provides information on policy initiatives to address elder financial exploitation, a serious and growing form of elder abuse.

Topics addressed include:

- Major Social Welfare Programs for Older Adults
  - Social Security Act
  - Older Americans Act
    - Administration on Aging
    - Administration for Community Living
  - Americans with Disabilities Act
  - Adult Protective Services
- The Elder Justice Act
- Responding to Financial Exploitation

The module provides an overview of how policies with respect to mandated reporting and funding have an impact on the ways in which states respond to the abuse, neglect, and exploitation of older adults and vulnerable adults with disabilities. Examples of strategies involving cooperation between adult protective services (APS), law enforcement, and financial institutions (macro-level interventions involving policy change) provide students with an understanding of policy changes and programs that will help protect older adults from financial exploitation. Social work recognizes the role of context and the impact of macro forces on the well-being of clients, and also recognizes that to help people, systems must change.

Elder justice policy is dynamic and changing. Resources cited, in addition to those listed at the end of the module, provide information on where instructors can find up-to-date information.

Major Federal Legislation (Macro-level Policies) Relevant for Elder Abuse

Social Security Act

An understanding of the provisions of the Social Security Act, which provide income support and health care to so many older Americans, is key to understanding issues related to elder justice. The Social Security Act, enacted in 1935, was a broad piece of legislation that originally contained two social insurance programs, three public assistance programs, and a number of smaller programs. Today, the programs under the Social Security Act include Old Age, Survivors, and Disability Benefits, Supplemental Security Income (SSI), Medicare, and Medicaid. Title XX of the Social Security Act authorizes the Social Services Block Grant (SSBG); many state APS programs are funded with SSBG funds. In recent years, block grants to states have been targeted for cuts or elimination.

"Social security," in popular usage, refers to the social insurance benefits put into place by the Social Security Act to prevent older adults from impoverishment in old age. Originally it was to be supplemented by the individual's retirement plan, pension, and savings, but it has become the sole source of income for one in five older adults (https://www.nasi.org/learn/socialsecurity/benefits-role).

The National Academy of Social Insurance provides resources, including PowerPoint slides, to help with teaching about federal old-age benefits (Reno & Walker, 2013). While older adults, as a group, are not as poor as children (9.5% of older adults living below poverty level versus 19.9% of children in poverty, according to 2013 Census data), social workers work with older adults with limited resources who are dependent upon these programs for survival (http://www.census.gov/newsroom/press-releases/2014/cb14-169.html).

SSI was created in 1972, replacing the former federal-state adult assistance programs in all 50 states and the District of Columbia. SSI provides monthly cash benefits to low-income older adults (over age 65), blind, and disabled adults. The program has nationally uniform eligibility requirements and federal payment standards. In most states, individuals eligible for SSI are also eligible for Medicaid.

Older Americans Act

The OAA was passed in 1965 to assist individuals over 65 years old and was amended in 1973 to include individuals 60 years and older. The OAA established the AoA within the Department of Health and Human Services (HHS) as the chief federal advocate for older Americans and assigned responsibility for elder abuse prevention to the AoA. In April 2012, HHS established the ACL, which brought together the AoA and the Office on Disability and the Administration on Developmental Disabilities to better align the federal programs that address community living services and support needs of both the aging and disability populations, among other things. The ACL serves as the advocate for individuals with disabilities and older adults in development of policies, programs, and regulations related to community living across the federal government. Formation of the ACL signaled recognition that policy concerns of the aging services network overlap in significant ways with those of the disabilities service network.

It is important to understand how elder justice activities, including elder abuse prevention, fit within the mix of programs that were started by the OAA. The OAA created the aging services network. The 56 State Units on Aging (SUAs) created by the OAA receive federal funds based on the older adult population in that state or territory (defined as 60 and over for most programs). The SUAs in turn fund local Area Agencies on Aging. The AoA also provides direct funding to Federally Recognized Tribal Organizations based on the number of tribal elders who are age 60 years and older.

The OAA authorized a wide range of programs. However, it was not intended to meet all community service needs or all people; programs focus on the needs of the most vulnerable older adults (individuals with low income, members of minority groups, older adults in rural areas, and frail individuals). Services focus on enabling older adults to "age in place."

Many OAA programs serve a planning, coordinating, and needs identification function. For a detailed overview that describes what each Title of the OAA provides for, see http://www.nhpf.org/library/the-basics/Basics_OlderAmericansAct_02-23-12.pdf. The OAA was last reauthorized in 2006, but Congress has continued to fund OAA programs.

Although the OAA created programs that provide important services and supports, the funding actually provided is relatively low and has decreased over the past two decades. With an increase in the older adult population, the needs of many seniors remain unmet.

Objectives: The OAA exists to "secure equal opportunity to the full and free enjoyment" of these objectives:

- Ensure adequate income

- Provide for physical and medical health
- Provide housing
- Provide restorative services
- Offer nondiscriminatory employment opportunities
- Promote continued well-being
- Promote self-determination
- Ensure retirement with dignity
- Provide community services
- Protect against abuse, neglect, and exploitation

A useful small-group activity in class is to have students identify and critique the OAA services in their communities. A sample activity ("Connecting Local Programs with State and Federal Policy") is included at the end of this module. Most of the OAA programs are found under Title III of the Act, which provides grants for state and community programs on aging. Title III programs include:

- Nutrition Program: Congregate meal sites (socialization) and home delivered meals ("Meals on Wheels") for the homebound. This is probably the most well-known OAA program.

- Home and Community-Based Services: Services funded include home care, adult day services, case management, transportation, and health promotion activities. These supportive services to assist older adults and the disabled with functioning tasks, Activities of Daily Living and Instrumental Activities of Daily Living, for continued independence. Because Medicaid accounts for a large portion of state budgets, programs that allow individuals to receive home and community-based services may help states save money on long-term care (LTC). The people that receive services provided under OAA programs are at a high risk of placement in nursing homes.

- Disease Prevention and Health Promotion: These programs, which must be evidence-based, are designed to support healthy lifestyles and health behaviors. The goal of using evidence-based programs is to reduce the need for more expensive medical interventions.

- National Family Caregiver Support Program: This program provides information and referral service to community-based services, e.g., counseling, respite, and support groups. Funds are limited, especially considering that family caregivers – the primary providers of LTC services in the community – provide billions of dollars worth of unpaid care every year. While caregiver stress is not the primary cause of elder abuse (see Module 1), services that address the needs of caregivers can help prevent the creation of conditions where abuse is more likely.

Title VII of the OAA authorizes activities to protect the rights of vulnerable elders. Funding levels are limited. It is important to note that funding for APS does not come from OAA funding.

- Long-Term Care Ombudsman Program: Serving as an advocate for client's rights, the program provides clients an avenue for increased empowerment, investigates complaints against LTC facilities, and provides information about LTC facilities

- Prevention of Elder Abuse, Neglect, and Exploitation Program: Established first in 1987, this program funds activities for the prevention of abuse, neglect, and exploitation. Program elements include training of professionals on how to recognize and respond to

elder abuse, outreach and public education campaigns, and support for state prevention coalitions and multidisciplinary teams. The National Center on Elder Abuse, a national resource center dedicated to the prevention of elder mistreatment, is funded through this program (see http://www.ncea.aoa.gov/index.aspx). As with all other OAA programs, funding is limited, but this program is an important component of federal elder justice initiatives that this module addresses further below.

Americans with Disabilities Act

The disability rights movement, which was inspired by the Civil Rights movement of the 1960s, pushed for the ADA, which was passed in 1990 and has transformed the way in which services are delivered to persons with disabilities. The ADA mandates the removal of barriers by government and private businesses that deny individuals with disabilities equal opportunity and access to employment, public accommodations, government services, public transportation, and telecommunications. It is designed to protect the civil rights of people with physical and mental disabilities, and it focuses on the concepts of disability and accessibility. The ADA established that people have the right to fully participate in their communities.

Policy changes brought about by the ADA have had an impact on the way in which services to older adults with disabilities have been structured and funded, and there have been considerable benefits for consumers of long-term services and supports, including older adults. The major thrust of the disability rights movement has been to advance an independent living philosophy – that services for persons with disabilities should be geared toward keeping them in their own homes whenever possible and providing them with control over how services are delivered. The focus is on access to independence, dignity, and choice – a philosophy consistent with elder justice. Under the Supreme Court's Olmstead decision in 1999, unnecessary institutionalization is seen as discriminatory and in violation of the ADA. Therefore, states must ensure that Medicaid clients are provided with services that will allow them to remain in the community. Progress on these matters has been uneven due to a number of factors, including state budget constraints and the Medicaid program's bias towards institutional care. The Independent Living movement, which has focused on "younger" adults and children with disabilities, has advocated the expansion of consumer-directed services. This movement has had an impact on services offered by the states, and this expansion has benefited older adults with disabilities as well.

Because LTC service delivery is largely the same for older adults as it is for younger adults with physical disabilities, states have refocused LTC services and supports to promote community living in the most integrated possible setting for adults of all ages with disabilities (Milne, 2012).

Adult Protective Services

To understand and work toward elder justice, social workers must understand the laws pertaining to and policy issues surrounding APS, state-administered programs that are funded in part by the SSBG. APS programs respond to and investigate allegations of physical and sexual abuse of older and dependent adults, neglect by caregivers, financial exploitation and self-neglect (the latter accounts for the majority of cases in most jurisdictions). APS responds to elder abuse that takes place in community settings in all states and to institution-based elder mistreatment in some states (U.S. Government Accountability Office, 2011). APS workers also arrange for services, such as guardianship, in-home aide services, and nursing home placement, and may provide continuing case management services.

An excellent resource on APS is the National Adult Protective Services Association (NAPSA): http://www.napsa-now.org/about-napsa/overview/. According to its website, "the goal of NAPSA is to provide APS programs a forum for sharing information, solving problems, and improving the quality of services for victims of elder and vulnerable adult mistreatment." APS minimum program standards can also be found on the website.

APS agencies participate in other multidisciplinary efforts, including Elder Abuse Forensic Centers (Schneider, Mosqueda, Falk, & Huba, 2010), the development of which are included in the Elder Justice Act (see below), and multidisciplianry teams addressing the complex needs of older adults who are reported to APS (Mosqueda, Burnight, Liao, & Kemp, 2004).

States differ on whether APS services are centralized, decentralized, a hybrid, or contracted out to private agencies (Mukherjee, 2011). Staffing and training vary by state as well. On the Federal level, the Elder Justice Act authorized $100 million in federal funding for state and local APS programs and support for the Long-Term Care Ombudsman program but no funds have been appropriated. Additionally, no federal laws or policies direct how protective services should be delivered. State statutes differ in terms of the definitions of abuse and types of abuse covered, and whether reporting of elder abuse is mandated (Brandl et al., 2007). New York State is the only state without mandated reporting. The funding of, accessibility to, and use of services are highly variable and dependent upon conditions in local APS offices (National Council on Crime and Delinquency and National Adult Protective Services Resource Center, 2012).

While localized control means that states and counties can determine the response that best fits the needs and resources of their communities, one result is that the United States does not collect uniform data that would help determine trends in reporting. Additionally, there is insufficient evidence-based research and dissemination of best practices to APS agencies, which thus have limited information on practices that would help them address complex cases (U.S. Government Accountability Office, 2011). The federal government is developing a reporting system that state APS agencies can voluntarily submit data (Colello, 2014).

Adult Protective Services and Mandated Reporting:

Mandatory reporting is a macro-level policy and is the law in most states. All social work students need to know their responsibilities with respect to mandatory reporting. The definition of who is mandated to report, where the reports must go, and the penalties for not doing so differ from state to state.

A useful exercise is to have the students look up the state's statute with respect to mandatory reporting of the abuse and neglect of older adults. Students can work on this in small groups in class, answering the following questions:

- Who is mandated to report abuse of older adults and adults with disabilities in your state?
- What are the responsibilities of the reporter?
- How does the state define abuse and neglect?
- Are older adults treated differently than younger adults with disabilities?
- What is the definition of "vulnerable adult"?

Students can also discuss any challenges they identify concerning implementing the state law on APS as written.

(Note: Mandatory reporting is also covered in Module 2: Social Work Practice with Abused, Neglected, and Exploited Elders.)

The Elder Justice Act – A Case Study in Policy Making

According to the EJA, elder justice, from a societal perspective, involves efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and to protect elders with diminished capacity while maximizing their autonomy. From an individual perspective, elder justice requires the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

> (Note: Instructors can use the EJA to illustrate to students why it is so important for social workers to be aware of the structure of the federal government, the role of different federal agencies, and how policies at the federal level shape potential responses.)

The EJA was enacted on March 23, 2010, as part of the Patient Protection and Affordable Care Act (PPACA). The EJA focuses on providing a coordinated federal response through various public health and social service approaches to the prevention, detection, and treatment of elder abuse. It also represents Congress's first attempt at comprehensive legislation to address abuse, neglect, and exploitation of the elderly at the federal level. However, the provisions of the act (explained below) have never been fully funded because of Congressional efforts to curtail discretionary spending by the federal government. The EJA provides us with an example of how progress in implementing worthwhile legislation is hampered by competing political priorities; in this case, ongoing disputes over federal spending priorities. The appropriations for the act expired in 2014; as of the writing of this curriculum, efforts are underway to pass standalone legislation.

The EJA passed after years of efforts by advocates. However, it does not represent the only policy or federal program directed towards elder justice. This section of the module describes the history and components of the EJA and other elder justice policy initiatives on the federal level (Colello, 2014).

The method by which the EJA garnered support and was eventually enacted provides an example of the long process of getting a law passed by Congress. For the past 40 years members of both the Republican and the Democratic parties have championed legislation to provide protection of older adults against abuse, neglect, and exploitation. In the 1970s, a series of field hearings on the "hidden problem" of elder abuse in the Senate Select Committee on Aging, which was chaired by Senator Claude Pepper of Florida, raised awareness. In 1987 Title VII of the OAA provided two programs related to elder justice – the Long-Term Care Ombudsman Program and activities to prevent abuse, neglect, and exploitation of older adults.

The Elder Justice bill grew out of these hearings and related work of the Senate Special Committee on Aging. Versions of the bill recognize that a multi-pronged approach from health care, social services, and law enforcement is required to address elder abuse. In 2002, Senator John Breaux, a Democrat of Louisiana, introduced the first EJA (S. 2933) in the 107th Congress. Since then, EJA legislation was re-introduced in subsequent Congresses. The Senate Finance Committee took action on bills in the 108th, 109th, and 110th Congresses with bipartisan support. Republican champions of the EJA have included Senators Orrin Hatch of Utah and Charles Grassley of Iowa, while Democrats have included Senators Herb Kohl of Wisconsin and Blanche Lincoln of Arkansas. Senator Hatch introduced the EJA of 2009 (S. 795) in the 111th

Congress. His version addressed public health and social services approaches to the issue. Representative Peter T. King, Republican of New York State, introduced a separate bill (H.R. 2006) in the House, which, in addition to the public health and social services provisions of the Senate version, also included criminal justice provisions. The Senate bill (S. 795) was incorporated into the Senate Finance Committee's health reform bill (S. 1796) and subsequently adopted in the Senate health reform bill (H.R. 3590), which became the Patient Protection and Affordable Care Act (P.L. 111-148).

The provisions of the EJA offer an overview of the multiple ways to respond to elder abuse. The EJA provisions also highlight how different branches of government have a role in addressing elder abuse.

The version of the EJA that passed included public health and social service approaches under the Department of Health and Human Services and did not include a criminal justice response that would address prevention, detection, and prosecution of elder abuse under the Department of Justice.

The EJA provided appropriations for several programs that are designed to address different aspects of elder abuse. The following list summarizes the major programs.

Elder Justice Act Provisions (Colello, 2014)

National Coordination of Elder Justice Research and Activities:

- Elder Justice Coordinating Council (EJCC): All heads of federal agencies and offices administering programs that address abuse, neglect, and exploitation are a part of the EJCC. The Council is required to submit a report to Congress every two years outlining recommendations for increased federal involvement in elder abuse. Visit the AoA's website for more information about the Council and recent activities: http://www.aoa.acl.gov/AoA_Programs/Elder_Rights/EJCC/index.aspx.

- Advisory Board on Abuse, Neglect, and Exploitation: A board of experts to advise the EJCC is charged with creating a short- and long-term multidisciplinary strategic plan.

- Elder Abuse, Neglect, and Exploitation Forensic Centers: EJA has provisions to establish forensic centers and develop forensic expertise. In elder abuse forensic centers, multidisciplinary teams of experts in health care, social services, and criminal justice can address complex cases by combining their forensic expertise, which involves applying scientific methods and techniques to establish facts and evidence in complex cases of elder abuse.

Programs to Promote Elder Justice:

- Enhancement of Long-Term Care: Programs to provide for training of direct care workers and electronic health records in LTC settings

- Adult Protective Services: The EJA calls for dedicated federal funding to APS, which currently do not receive any dedicated funding from the federal government (even though many states have used SSBG or OAA monies to supplement state and local funding). The EJA also provides for grants to improve APS programs and demonstration grants to try new approaches to APS (see description of Texas Elder Abuse Prevention and Intervention Grant described below).

- Long-Term Care Ombudsman Program: The program, which provides a mechanism for LTC consumers to address problems in nursing homes and other LTC facilities that are affecting them, was established by the OAA (Title VII). The EJA would fund grants to improve the experience and expertise of LTC ombudsman programs in their dealing with elder abuse and neglect.

Protecting Residents of Long-Term Care Facilities:

- National Training Institute for Surveyors: The EJA provides for this program that would improve training for those who inspect LTC facilities that receive funding from Medicare or Medicaid for compliance with those programs. EJA-funded training is aimed towards improving the surveyors' ability to investigate complaints of abuse, neglect, and exploitation.

- Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities: The EJA amends federal law to require those who own or work in federally funded LTC facilities to report crimes against residents or individuals receiving care from those facilities.

- National Nurse Aide Registry: The EJA authorizes funds to conduct a study on establishing a national nurse aide registry. The purpose of this registry would be to provide a national database of nursing aides who have completed training and registration requirements for the state in which they work; this database would also keep track of nursing aides who can no longer work in LTC facilities due to substantiated findings of abuse, neglect, or exploitation.

The EJA has accomplished a number of things. Since its passage, the ACL/AoA have made grants totaling $5 million to implement, test, and measure performance of new approaches to identify, intervene, and prevent elder abuse. Grants of $700,000 were made available to three tribal organizations to develop culturally appropriate screening and training tools.

Demonstration grants are one way in which the government provides support in the development and testing of new approaches to intervention; the theory is that successful programs can be replicated and expanded.

One example is the Texas Elder Abuse Prevention and Intervention Grants, which includes Texas Department of Family and Protective Services, WellMed Charitable Foundation, and the University of Texas Health Science Center at Houston. Under this program, doctors in a primary care setting received training in the use of a screening tool to identify and report elder abuse to Texas APS. The tool enabled doctors to identify patients as at high, medium, or low risk for abuse; and doctors were asked to follow protocols for further action, including reporting the high-risk patients to APS. Texas APS staff was also "embedded" in the health care system to facilitate referrals and provide consultation.

Elder Justice Act – Discussion

An examination of the programs under the umbrella of the EJA teaches students about different approaches that have gained traction among policymakers. These approaches have the backing of advocates, experts in the field, and interest groups. Learning about these different programs also gives students a sense of what current thinking is concerning what is needed to address elder abuse. Two discussion questions should be considered. What is missing from the EJA? Are important priorities addressed or not?

The EJA gives federal attention to elder abuse much like the Child Abuse Prevention and Treatment Act of 1974 gave federal support and recognition to the issue of child maltreatment and the Violence Against Women Act (1992) highlighted the importance of a federal response to domestic violence. Another vital question arises: Why has attention to elder justice lagged behind attention to child maltreatment and violence against women?

Responding to Financial Exploitation – Connecting Macro- and Micro-Level Policy

Financial exploitation of older adults can take many forms and has enormous emotional and financial costs. Difficulty in detection of abuse, prosecution of cases, and recovery of lost assets make prevention and early detection important. When working with older adults, social workers must be aware of the potential for different types of financial exploitation, the remedies available to address it, and the efforts underway to change policy so that there is less opportunity for the well-being and security of older adults to be compromised.

A study conducted in New York State revealed that financial exploitation was the most common form of elder abuse, affecting 41 per 1,000 older adults (Lifespan of Greater Rochester Inc., Weill Cornell Medical School of Cornell University, & New York City Department for the Aging, 2011).

From both a practice and policy perspective, an understanding that multiple types of financial exploitation exist is very important. For example, older adults (along with consumers of any age) may be victims of consumer fraud, which includes the use of deceptive practices that result in loss as the result of a business transaction that seems legitimate. The Dodd-Frank Wall Street Reform and Consumer Protection Act, passed in 2010, established the Office of Financial Protection for Older Americans (OFPOA) to increase ways to secure protection and financial well-being for adults age 62 and older. Resources available from the OFPOA encourage older adults to ask questions to those who want to manage their money, to safeguard their personal financial information, to plan ahead for retirement, to safeguard their home equity, and to resist pressure to make quick decisions involving spending money. Social workers need to be aware of these and other resources available for both older adults and family members or other caregivers who manage their money.

The type of financial exploitation and the interpersonal dynamics differ depending on the relationship between the victim and offender. Strangers tend to exploit older adults with frauds and scams, whereas service professionals such as financial planners may exploit older adults with either theft or fraud. Family members tend to use theft and misuse of assets. Brief vignettes available from the Department of Justice's Elder Justice initiative website illustrate the different types of exploitation, and can be used as a basis for discussion of what the policy and practice responses should be (http://www.justice.gov/elderjustice/financial/common-scenarios.html).

Social workers need to be able to recognize and address potential financial abuse by relatives and caregivers and to work with community partners. APS relies on community partners and mandated reporters to support its efforts to reduce abuse, neglect, and exploitation. Because of the alarming increase in the scope of financial exploitation (the fastest growing category of reports to APS) of older adults, new service strategies have been developed that provide an example of social services reaching out and working with banks and other financial institutions.

One example is a bank fraud protection reporting program started by the APS agency in Philadelphia and Wachovia Bank (Snyder, 2012). The director of the APS agency approached the bank because APS needed help in identifying financial abuse sooner to minimize loss of assets to

older adults who were subject to exploitation. Bank tellers and other bank employees often witness customer behavior that raises red flags, and they are not always aware of strategies to deal with it. Some older adults become susceptible to manipulation by loved ones or may be coerced into using their resources to support younger family members. Before the bank would agree to participate in training their employees and reporting suspicious cases to APS, they needed assurance that they were not violating Federal privacy laws, a protocol for response to suspected cases of financial exploitation, and training.

Because of the growth and devastating impact of cases of financial exploitation of older and disabled adults, many state departments of social services through their adult services programs have joined forces with other organizations, including financial institutions and law enforcement, to address financial exploitation. For example, Financial Abuse Specialist Teams (FAST) are multidisciplinary teams that address financial abuse of older and vulnerable adults (Malks, Schmidt, & Austin, 2002). (See also http://www.ncea.aoa.gov/Stop_Abuse/Teams/FAST/index.aspx).

These programs illustrate how macro- and mezzo-level policy changes have led to increased detection of financial exploitation, which helps protect older adults from loss.

Discussion: Need for Policy Change

Elder justice policy is dynamic and changing. Interest by practitioners, advocates, and lawmakers in improving policy responses to abuse, neglect, and exploitation, combined with competing demands and scarce resources, means that social workers must pay attention to this important policy arena on the federal, state, and local levels. Some areas for discussion include:

- Definition of "elder." Does it make sense to shape policy with respect to age, or should policy focus on the vulnerability or lack of capacity? Without a clear definition it is impossible to compile accurate data regarding the needs and trends of the aging population.
- National definition of elder abuse.
- A coordinated interdisciplinary delivery system of services.
- A need for an intergenerational focus for programs and policies.

Policy Exercises

Case studies: The case vignettes in the elder justice modules raise issues related to potential financial exploitation and address services needed for older adults. Have students identify policies or policy changes needed to serve the clients more effectively.

Connecting local agency services with federal and state policies: This small-group activity helps students connect macro-level policies with elder justice resources in their community. This activity requires that students have access to laptops, tablets, or smartphones, and an Internet connection.

Present students with an overview of policies related to elder justice.

Divide students into small groups of three or four. To get them started, direct them to the Elder Justice Initiative: http://www.justice.gov/elderjustice/ or your state office on aging.

Instructions for students: Working with your group, answer the questions within the scenarios below. Be sure to be as specific as possible, include names and phone numbers if available.

- Your grandmother is in a nursing home. The red spot on her back has turned into an open sore. You've mentioned it to the nurse in charge several times, but no one seems to be doing anything about it. Whom do you call?

- Your grandfather with dementia is living with your parents. He has grown more combative, especially in the evenings when your father tries to help him get ready for bed. Last night, he punched your dad in the face and your dad, frustrated, hit back. What support is available for your parents? For your grandfather?

- A lonely neighbor who uses a walker is looking for some place to eat meals with other older adults. What meal sites are available and accessible for her?

- Your great aunt, age 85, lives alone in the small house that she shared with her husband, who died five years ago. Your mother tells you she has "slowed down" and is "stubborn" about getting help. When you visit, you are surprised to find that there is little food in the house and no heat. She refuses your assistance. What resources can you seek out?

Once your group has identified resources, identify how each resource is connected to the OAA or other state or federal law. You may want to look at specific titles of the act and the different programs funded.

Summary

Advocates for elder justice are encouraged by policy activity at the federal level in recent years. The content and exercises in this module acquaint students with policies addressing elder justice, which exist within the framework of federal policies serving older adults, including the Social Security Act, the OAA, and the ADA. APS, which serves as a first responder to elder abuse, is administered at the state level and funded from Social Services Block Grants. The EJA is the first major piece of federal legislation that would provide a dedicated funding stream for APS and federal direction for this vital program, and its history of support and eventual passage provides a case study of the policy making process.

Social workers must be knowledgeable about the policies that determine the services that are available to older adults. They must work towards the preservation of vital programs and advocate for policies and services that will provide a strong response to the abuse, neglect, and exploitation of older adults.

Resources

Elder Justice Coalition: Coalition of membership organizations, including National Adult Protective Services Association and the National Committee for the Prevention of Elder Abuse, and interested individuals that advocates for federal legislation related to elder justice. (http://www.elderjusticecoalition.com/)

Elder Justice Roadmap: This initiative, sponsored by the Department of Justice and the Department of Health and Human Services, asked 750 stakeholders to complete, with as many ideas as they wished, the following statement: **"To understand, prevent, identify or respond to elder abuse, neglect, or exploitation, we need..."** The responses were analyzed using concept mapping, which is an analytic technique that creates clusters of ideas based on common themes. The resulting document will be used by advocates to highlight priorities for action related to elder justice in direct services, education, policy, and research. (http://ncea.aoa.gov/Library/Gov_Report/docs/EJRP_Roadmap.pdf)

National Center on Elder Abuse government reports page: Comprehensive collection of reports conducted by different agencies in the federal government. Includes link to the **Elder Justice Roadmap** and Government Accountability Office reports on adult protective services, federal elder justice activities, and guardianship, among others. (http://ncea.aoa.gov/Library/Gov_Report/index.aspx)

National Council on Aging – Public Policy Action: Updates on policy issues affecting older adults, including those related to EJA and the OAA. (http://www.ncoa.org/public-policy-action/elder-justice/)

National Indigenous Elder Justice Initiative: Addresses "the lack of culturally appropriate information and community education materials on elder abuse, neglect and exploitation in Indian Country." Resources on efforts to increase elder abuse prevention and intervention efforts. Funded by the Administration for Community Living. (http://www.nieji.org/)

United States Department of Justice: This Department of Justice page consolidates information on its elder justice efforts. There are a number of resources, many of which are focused on the intersection of elder abuse and the criminal justice system. Short vignettes provide examples of different types of abuse. (http://www.justice.gov/elderjustice/)

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