

Elder Abuse, Neglect, and Exploitation

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Background

Elder abuse is one of the most disturbing and rapidly growing areas of crime in the United States. First recognized by Congress in hearings some 25 years ago, it remains a national disgrace and hidden phenomenon in our communities. While variously defined, elder abuse can encompass a range of destructive behaviors directed at older adults including acts of commission, considered to be abuse, and acts of omission, categorized as neglect. Abuse and neglect may be intentional or unintentional, financial or material exploitation, and self-neglect (National Center for Elder Abuse, 2003; Hamilton, 2003). All threaten the health and welfare of an older person. The boxes below provide expansion on the definitions of abuse, neglect, and exploitation (Maine DHHS/OES, 2003):

Abuse

Abuse includes actions which result in bodily harm, pain or mental distress. Examples of abuse are:

- pushing, hitting, shaking, pulling hair
- tying to a bed or chair or locking in a room
- forcing into sexual activity
- giving the wrong medicine or too much medicine on purpose
- denying visits with friends or family
- name calling, harassment or verbal threats

Neglect

Neglect is a failure to provide care and services when an adult is unable to care for him or herself. Neglect may be at the hands of someone else or it may be self neglect. Neglect includes failure to provide:

- adequate shelter, clothes or food
- personal care
- medical attention or necessary medication
- necessities such as glasses, dentures, hearing aides, walkers

Exploitation

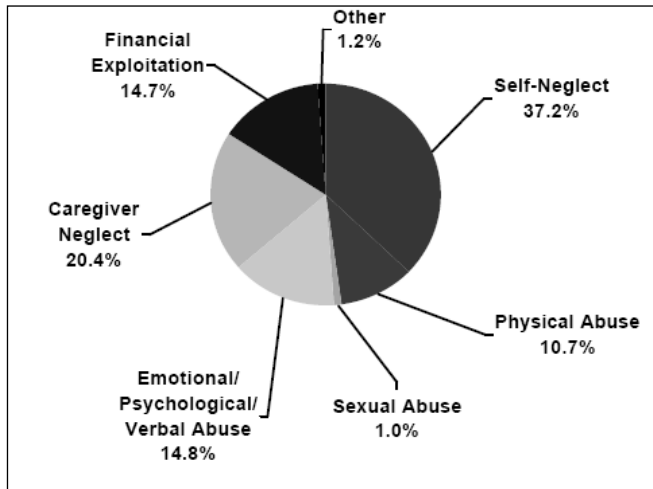
Exploitation is the illegal or improper use of an adult's money or property for another person's profit or advantage. Examples of exploitation include:

- forcing an adult to change a will or sign over control of assets
- forcing an adult to sell or give away property or possessions
- keeping the adult's pension or social security check

Prevalence

It is estimated that as many as 5 million persons 65 and older are abused in the United States annually. Approximately 84% of all cases of abuse are never reported (Legal Services for the Elderly, 2001). Maine, the nation's oldest state in median age and second most rural state, has a rate of elder abuse estimated to be above the national average (Hamilton, 2003; Maine DHHS/OES, 2006). In addition, Maine's elderly suicide rate is among the highest in the United States (Associated Press, 2002). In Maine, it is estimated that only one of every 14 incidents of elder abuse is reported (Legal Services for the Elderly, 2001). This represents an estimated total of approximately 14,000 victims annually, the vast majority of whom are unknown to the state's health and welfare system and therefore do not benefit from the services available to address elder abuse, neglect, and interpersonal violence (Hamilton, 2003; Maine DHHS/OES, 2006).

The graph below presents the most recent national survey data from the National Center on Elder Abuse (Teaster, et al., 2006).



Substantiated Reports of Elder Abuse by Category (2006)

1. Self-neglect was the most common category of substantiated reports (37.2%),
2. Caregiver neglect (20.4%),
3. Financial exploitation (14.7%)

Problem Statement

Elder Abuse Remains a Hidden Problem

The majority of cases of elder abuse go unreported making it a hidden problem within the communities that we live in. There are many reasons why abuse goes undetected. Often the abuser is a family member and caregiver who is the sole lifeline for the dependent victim's basic needs. Many older adults tolerate abuse rather than risk losing the close personal ties of the abusive family member who is most often a child or a spouse. Victims tend to minimize the seriousness of the abuse so as not to place the abuser at risk, or fearing institutionalization, to jeopardize their living arrangement. There is a common belief that these types of issues are "family matters" and should be handled within the family itself. However, because the abuser is often times a member of the family, there is a tendency for other family members to cover up the situation. Also, there is a tendency for the victim to blame him or herself for the abuse or want to protect the abuser from "getting in trouble." There has been some progress over the last few decades in raising public awareness of the epidemic of elder abuse in America. There have been research studies, demographic reports, as well as anecdotal studies focused on elder abuse. However, despite all of these steps forward, elder abuse can be considered to be where child abuse and domestic violence were 25 years ago (i.e., at the "tip of the iceberg" stage of overall public awareness). There are several reasons for this - elder abuse is not clearly defined, funding for elder abuse intervention and prevention is limited, and the public has not yet taken elder abuse into its vernacular (Solomon, 2006). In 1998 the Administration on Aging published its final report on The National Elder Abuse Incidence Study. This study advocated for a sentinel approach to elder abuse using the model developed by Westat for officially reporting child abuse (Administration on Aging, 1998). This approach is based on the assumption that reported cases of elder abuse represent only the "tip of the iceberg", and that most cases are not reported to Adult Protective Services (APS).

Trends

Nationally

Elder abuse should be a growing concern to all of our citizens and be considered a significant public health issue. The creation of a national strategy for promoting elder justice through prevention and prosecution of elder abuse was one of the top 50 resolutions to come out of the 2005 White House Conference on Aging as voted on by conference delegates (WHCoA, 2005). The most rapidly growing segment of the U.S. population is adults aged 60 and older. By the year 2050, it is expected that more than 20% of the American population will be 60 years old or older; the number of abused citizens will also grow in proportion to this increase (Wright, 2006). A study by Lachs, et al. (1998), researchers from Cornell and Yale Universities, demonstrated that older adults subjected to abuse and neglect were at a significantly higher risk for death than non-abused elderly. Those at greatest risk are the most dependent, the oldest of the old. The prognosis for abuse rivals more traditional types of illnesses, such as hypertension and angina. Victims of elder abuse make twice as many visits to hospitals and doctor's offices, are more dependent on federal health care programs, and have higher outpatient expenses than their non-victimized counterparts (Wright, 2006).

National Trends - Abuse of Vulnerable Adults 60+ Reported to Adult Protective Services (APS)

- APS received a total of 253,426 reports on persons aged 60+
- APS investigated a total of 192,243 reports on persons aged 60+
- APS substantiated 88,455 reports on victims aged 60+
- APS received 84,767 reports of self-neglect on persons aged 60+
- APS substantiated 46,794 reports of self-neglect on victims aged 60+ (Teaster, et al., 2006)

Other National Trends

- Estimates of the frequency of elder abuse range from 2 to 10% (Lachs & Pillemer, 2004).
- One in 14 incidents, excluding self-neglect, come to the attention of authorities (Pillemer & Finkelhor, 1998).
- The overall reporting of financial exploitation is only 1 in 25 cases, suggesting at least five million financial abuse victims each year (Wasik, 2000).
- One large survey of staff working in nursing homes found that 36% had observed physical abuse and 81% witnessed psychological abuse (Pillemer & Moore, 1989).

Maine Trends

In Maine it is estimated that only 7% of elder abuse cases are reported making those older adults affected by abuse a severely unidentified and underserved population (Legal Services for the Elderly, 2001). Elder abuse is nondiscriminatory in the sense that it spans all economic, ethnic and cultural backgrounds. Individuals are not necessarily aware that they are at-risk of abuse, neglect, or exploitation. Because Maine is a rural state, services are limited and individuals may be even more unaware of the occurrences of elder abuse and its symptoms. One of the only services that isolated elders may receive on a regular basis is an appointment with their primary care physician. As a result, this may represent an appropriate and effective place in which to screen for abuse (Administration on Aging, 1998).

Maine Statistics

Maine now has the oldest population in the nation, with 19% over the age of 60 years. As a state we are rapidly approaching one in five citizens being over age 60. Maine is second in the nation for percentage of residents age 65+ living in rural areas. Thirty percent of Maine's older adults, age 65+, live alone, with women comprising 76% of those living alone. Isolation is a risk factor in elder abuse and neglect making those living alone at particular risk. Elder abuse has no boundaries, it affects women and men of all cultural and socioeconomic groups and levels of physical and mental functioning (Maine DHHS/OES, 2006).

Maine Adult Protective Services (APS)

Maine's Adult Protective Services program protects adults who are unable to protect themselves from abuse, neglect or exploitation. In 2005, Adult Protective Services Intake received over 14,000 calls. APS validated allegations of abuse, neglect or exploitation in 48% of all investigations in 2005. The national average is approximately 60%. Sixty-six percent of APS clients are older adults, age 60+. Of these older adults served by APS, 59% are female and 41% male. Protective Case Management Services include services for older victims of domestic violence. There are many more victims of elder abuse in Maine than ever get reported to APS (Maine DHHS/OES, 2006).

Financial Exploitation

Financial exploitation can be indicated by: sudden changes in banking practices, the inclusion of additional names on an older adult's banking card, unauthorized withdrawals, abrupt changes in the person's will, the unexplained disappearance of funds or valuables, unexplained transfers of funds to family members, and forged signatures on financial documents (NCEA, 1998). The inability or unwillingness to provide adequate basic care or medical care, such as filling prescriptions or transporting to appointments, may be financially motivated. Financial abuse is a precursor to more gross forms of abuse and often the underlying cause of other forms of abuse and exploitation (Hwalek et al., 1996; Stiegel, 2005). The overall reporting of financial exploitation is only one in 25 cases, suggesting at least five million financial abuse victims each year in the United States (Wasik, 2000). Some risk factors for financial abuse may stem from diminished mental capacity, susceptibility to undue influence, or inexperience handling finances (Nerenberg, 2006). Abuse of powers of attorney has gained some attention recently as reports of agents using their powers to exploit rather than protect have become more frequent (Nerenberg, 2006). One study that interviewed older women survivors of abuse recommended that estate planners should be cautious about encouraging older people to sign over their residences to their children for tax and estate benefits (Hightower, 2006). As mentioned previously, end of life can put older adults at risk for abuse because many of the risk factors for abuse are acquired as the person health status declines. Family members who financially abuse a dying patient often express the attitude, 'it's all going to be mine soon anyway.' (Jayawardena & Solomon, 2006).

Options

Screening for Elder Abuse in the Primary Care Physician's Office

In searching for health-care system responses to the problem of elder abuse, it is important to note that primary care practices may be the most trusted and generally accepted site for coordination of services. As such, primary care must be considered a prime entry point into the greater health and welfare system (Administration on Aging, 1998). For that reason, older patients' physicians are in an ideal position to pose questions that would permit disclosure of potential and actual abuse, neglect, and exploitation. Unfortunately, studies show that large proportions of health care professionals have little knowledge of elder abuse or of the resources available to address it (Tilden, et al., 1994; Hendricks-Matthews, 1997; Alpert, et al., 1998). Although abuse is known to have major health-related impacts including depression, severe emotional distress, and increased mortality, physician-initiated screening to identify potential and actual mistreatment is not a routine element of current primary care practice.

Assessment of Elder Abuse Victims

It can be particularly challenging when conducting a physical assessment to distinguish the normal dying and aging processes from abuse. The patient's general appearance may give clues to common signs of abuse and neglect including dehydration, poor nutrition, and bed sores (Jayawardena & Liao, 2006). The victim of abuse should be questioned and assessed alone, without the caregiver present, followed by questioning with the caregiver present. The reason for this is the possibility that the caregiver is also the abuser and separate interviews can reveal discrepancies (Brown, Streubert, & Burgess, 2004). The National Elder Abuse Incidence Study (NEAIS) reports that the most important signs of elder abuse include the client's fear or suspicion of another person in the home or recurrent and unexplained crying (Thompson & Priest, 2005).

Prevention

An Outline of Preventive Interventions to Address Elder Abuse is Listed Below (Westley, 2005):

- Educating professionals about potentially abusive situations
- Educating the public about normal aging processes
- Helping families develop and nurture informal support systems
- Linking families with support groups
- Teaching families stress-management techniques
- Arranging comprehensive care resources
- Providing counseling for troubled families
- Encouraging the use of respite care and day care
- Informing families about resources for meals, transportation, in-home care
- Utilizing the long-term-care ombudsman program to address quality of life issues in long-term care
- Encouraging caregivers to pursue individual interest for self-care

Adult Protective Services Intervention

Adult Protective Services is a program within the Office of Elder Services. The Office is part of the Department of Health and Human Services. Its purpose is to provide and arrange for services to protect adults who are unable to protect themselves from abuse, neglect or exploitation. If the person has mental retardation, services are provided by the Department of Behavioral and Developmental Services. Any dependent or incapacitated adult who may be in danger of abuse, neglect or exploitation may receive assistance from Adult Protective Services. A dependent adult is a person who is wholly or partially dependent upon other people for care and support, either emotional or physical, and who would be in danger if that care and support were withdrawn. An incapacitated adult is a person who lacks sufficient understanding to make or communicate decisions about his or her own person or property. These adults may need someone else to make some or all of their decisions for them (Maine DHHS/OES, 2003).

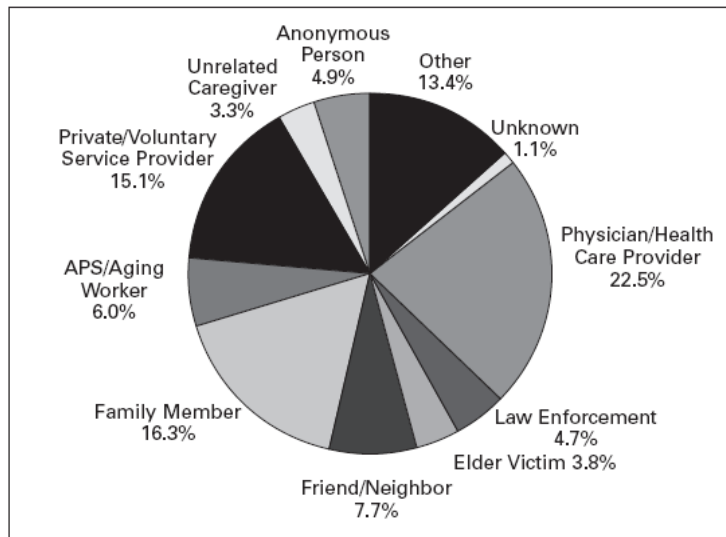
Clients of Adult Protective Services May Include:

- frail or vulnerable elders
- people with mental illness
- those with alcohol or drug abuse problems
- those with medical problems or disabilities

Mandatory Reporting of Adult Abuse, Neglect or Exploitation

Maine law states that certain people must report suspected abuse, neglect or exploitation of an adult if they believe the adult is incapacitated or dependent. Persons convicted of failing to report may be fined up to \$500. If the person is a professional, the court or DHHS also will report to that person's licensing board or accrediting unit. Persons with responsibility to report abuse include those who have assumed full, intermittent or occasional responsibility for the care or custody of an incapacitated or dependent adult, whether or not the person receives compensation; or any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, whether or not the person receives compensation (Maine DHHS/OES, 2003).

The goals of interventions are to stop the abuse of older adults and hold the perpetrators accountable. Important considerations are to determine if the older adult is in immediate danger and what can be done to increase their safety. Also, it is essential to know what barriers exist to helping the individual as well as what resources are available in the community.



The law requires that clinicians and other professionals working in the "helping" fields report cases of elder abuse. This can be done by calling the police if there is immediate danger; contacting local Adult Protective Services to request an investigation; or speaking to the long-term care ombudsman for advice and assistance. A written report should include documented

observation of the patient and caregiver and a detailed history of both a typical day as well as instances of possible abuse, neglect, or exploitation (Westley, 2005). The graph above reflects the different categories of persons reporting elder abuse (Westley, 2005).

Mandated Reporters in the State of Maine

Ambulance Attendant	Occupational Therapist
Certified Nursing Assistant	Pharmacist
Chiropractor	Physical Therapist
Clergy	Physician (M.D. and D.O.)
Dentist	Physician's Assistant
Emergency Medical Technician	Podiatrist
Emergency Room Personnel	Psychologist
Humane Agent	Registered Nurse
Law Enforcement Official	Social Worker
Licensed Practical Nurse	Speech Therapist
Medical Examiner	Unlicensed Assistive Personnel*
Medical Intern	*(includes Personal Care Assistant/PCA)
Mental Health Professional	(Maine DHHS/OES, 2003)

Barriers

Risk Factors of Abuse, Neglect, and Exploitation

Older adults who are dependent upon family members are particularly vulnerable. Here are some ways that this type of family violence can take place:

“Abusers may threaten to institutionalize the victim or deny access to grandchildren. Isolation may be easier to accomplish with an older person by taking mail, denying access to the phone, etc. Victims who rely on others for help with finances may be abused through misuse of powers of attorney, giving away assets, or taking over property. Neglect is a type of abuse more dangerous when victims are dependent on an abuser. Abusers may fail to change bedding, deny food and water, or interfere with medical care. Specific disabilities and medical needs can also be exploited” (Jordan, 2002, p. 149).

A lack of caregiving experience, knowledge of resources, or inability to provide an appropriate level of care can put elders at risk for abuse from their caregivers. It has been found that stressed or overburdened caregivers are more likely to abuse their relative, especially when the relationship was poor to begin with (Anetzberger, 2000). It has also been found that older adults are at much higher risk for being abused at the end of life because many of the risk factors for abuse are acquired as the person health status declines (Jayawardena & Liao, 2006).

Risk Factors for Elder Abuse, Neglect or Exploitation (Maine DHHS/OES, 2003)

- Misunderstanding of an adult’s physical or emotional needs or abilities
- Stress because of financial, family, marital or health problems
- Alcohol or drug abuse
- Mental illness
- Lack of training or education
- Social isolation

Alcohol Abuse and Elder Abuse

National statistics for the United States reveal that 44% of male and 14% of female abusers of parents (age 60 years and over) were dependent on alcohol or drugs, as were 7% of victims (Greenberg, McKibben, & Raymond, 1990). Alcohol consumption by victims of elder abuse has been closely associated with self-neglect (Choi & Mayer, 2000). For older adults, having an adult relative with a drinking problem is a risk for being a victim especially when the relative is dependent on the older adult for housing or supports the relative financially. Older people are more likely to remain in an abusive relationship when their abuser is a highly dependent adult offspring or spouse (Seaver, 1996). Both alcohol problems and elder abuse can be overlooked as a result of ageist beliefs that memory problems and social withdrawal are part of the normal aging process (Bradshaw & Spencer, 1999).

Ageism

Ageist beliefs are still present in today's society. These beliefs place a stigma on growing old and permit younger generations to distance themselves from their older relatives by utilizing stereotypes that perpetuate aging myths. Some of these stereotypical views are: seeing older people as senile, as inflexible in thought and behavior, as having old-fashioned views on morality, and as being physically feeble, frail, and slow. Ageism contributes to prejudice against older individuals and puts elders at risk for abuse and neglect (Quinn & Tomita, 1997; Thompson & Priest, 2005). There is a similar denial regarding elder abuse that exists around death and dying issues by American society (Jayawardena & Liao, 2006).

Domestic Violence in Older Adults

In general, domestic abuse is defined as a pattern of coercive behavior used to establish power and control over an intimate partner that often creates an environment of fear for the victim. Some argue that the metaphor of domestic violence as chronic disease is a useful way to look at the problem for healthcare professionals (Lachs & Pillemer, 1995; Solomon, 2006). There are varying estimates as to the prevalence of domestic violence cases among older Americans. One study estimated between 4% and 6% of the older adults living in North America reported being in physically abusive relationships which translates to between 3 and 5 million Americans over the age of 50 currently in such relationships (France, 2006). Older women in abusive relationships that have had limited work experiences outside the home face the "catch-22" scenario of a choice between economic security and continued abuse, or poverty and relative safety. Potential losses of older women who choose to leave an abusive relationship are different than those of younger women in similar circumstances. Some of the most notable losses would be loss of financial security and loss of home and mementos. A number of older women in abusive relationships report observing disturbing behavior patterns of their own children as parents and adult partners, thus continuing the cycle (Hightower, 2006). In conducting a nationwide search in both the U.S. and Canada, one researcher found only 30 support groups designed specifically for elderly victims of domestic violence (Lachs, & Pillemer, 2004). Regarding domestic violence shelters, it has been found that shelters often do not adapt their services to the needs of older women and older women tend not to use women's shelters (Straka & Montminy, 2006). Older women often face great financial barriers that often keep them in

abusive relationships. They are more likely to have health or functional problems that make them dependent on someone for care, and this makes it more difficult for them to seek help or to leave. Older women experiencing domestic violence may become resigned to living in situations of longstanding abuse and may be unable to realize that there are choices (Wolf, 2000).

Elder Homicide-Suicides

Elder homicide-suicides usually involve spouses or intimate partners who kill their partners and then commit suicide. These killings are often prompted by the physical decline, hospitalization or institutionalization of one of the individuals in the relationship. The events are often mistakenly assumed to be ‘double suicides’ or ‘mercy killings’, however, when the cases are looked at with closer scrutiny, it is usually revealed that one partner was not a willing participant. Many homicide-suicides appear to be motivated by the perpetrators’ need to control the other person. In fact, in 33% of such cases, there is a history of domestic violence (Cohen, 1998).

Raising Awareness/Healthcare Network Education

Education is another key aspect for a multidisciplinary team approach to be effective. Much literature cites the lack of adequate training of medical personnel on elder abuse and neglect. A survey by Hendricks-Matthews (1997) of medical education programs and residency programs in Virginia found that elder abuse was rarely addressed in the curricula. A study in 1998 by Alpert et al. reports that in the past decade the number of medical schools in the United States with elder abuse in the curriculum had increased, however, total instructional time and clinical training instructional time had not changed (Loue, 2001). This deficiency was found to be true of nursing curricula as well. Content on elder abuse in health professional texts had also been evaluated and is sorely lacking (Loue, 2001). Medical personnel learn little about elder abuse in their formal educational programs, and there are few alternative opportunities available through professional continuing education programs (Kahan & Paris, 2003). The wall of silence about elder abuse and neglect within the health care profession further jeopardizes frail elderly. Professional training programs on elder abuse and neglect are essential in order to fill this obvious gap in medical personnel’s education. The incorporation of training on elder abuse into medical education should be a high priority; training in elder abuse as a requirement for licensure or simulated teaching cases of elder abuse in clinical presentations to appeal to physicians are some strategies to fill this gap in continuing education (Lachs, & Pillemer, 2004).

Implications

Nationally

Leigh Martinez White offers an analysis of the state of the proposed Elder Justice Act in her commentary below:

Despite a robust response when the issue was first raised in congressional hearings twenty-five years ago, to date no federal regulations have been promulgated that deal with what was once described as a “disgrace” and a “burgeoning national scandal.” State agencies were quick to respond to the issue, enacting numerous laws and programs

to identify and combat the problem. However, chronic underfunding of state elder abuse programs has led to an inconsistent patchwork of statutes that vary by state and, more important, authorize limited resources to assist the victims...State and community agencies are struggling to care for the elderly victims who are reported to them each year, but it may be up to the federal government to pass the legislation that will effectively coordinate and adequately fund their effort” (Wright, 2006, p.1).

State of Maine

An increase of funding for Adult Protective Services is essential to continue their efforts as the lead agency fighting elder abuse in Maine. It is crucial to raise awareness of the prevalence and impact that elder abuse has on our older citizens. This awareness needs to be in the form of a coordinated educational effort targeting the general public, health-care system personnel, policy makers, and older adults. Overcoming many stigmas associated with elder abuse such as shame and guilt are significant barriers that prevent older Mainers that need help from seeking it out. By doing a better job of educating older adults about what resources are available to them and that there are places to turn to for help is a key piece of tackling the elder abuse problem in Maine. There needs to be an effort to make emergency shelters for older adult victims of abuse available and accessible to those that need them. There is great importance to support grass-roots elder abuse prevention efforts and for policy-makers to recognize the effectiveness of victims telling their stories when considering outreach strategies and campaigns. There is also a “denial factor” to overcome– victims, families, and politicians tend to deny the severity of the problem - its existence as well as its prevalence in Maine.

2006 Blaine House Conference on Aging Regional Forum Recommendations:

- Elder abuse needs to become part of public discussions in order to remove the shame associated with abuse; there needs to be better enforcement of the laws with adequate punishment showing the seriousness of the crime; the state needs to increase its education and information efforts and set standards of care in all health care arenas, making them accessible to older adults
- A spokesperson for elder issues from the state/governor’s office should release weekly information/awareness statements
- Public awareness on elder abuse issues from the governor’s office/OES is necessary including how to report and access the APS phone number
- Closer monitoring of the long-term care patients access to “bill of rights” is needed
- A process for intervention without prosecution is needed to lessen fear of reporting abuse
- More community health/social workers to monitor isolated elders are needed
- Establishing an anonymous caregivers hotline to self-report abusive behavior is needed
- Stiffer penalties – felony statutes for elder abuse crimes should exist
- Network existing services for homebound elders to identify vulnerable adults – link with law enforcement
- More local enforcement and available resources for officers is needed
- Financial Institutions – exemption from confidentiality in order to report elder abuse.
- Education of the general public around the signs of elder abuse is recommended
- Abuse screening and employee background checks in long-term care are needed
- Credit card abuse warrants increased attention

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