

## Community Approaches to Elder Abuse

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The National Elder Abuse Incidence Study estimated that in 1996 at least one half million community-dwelling elders experienced abuse, neglect, or self-neglect [1]. A longitudinal study of a large cohort of community-dwelling older adults revealed Adult Protective Service (APS) use prevalence of 6.4% over an 11-year period [2]. Although other epidemiologic studies have estimated the prevalence of elder mistreatment (abuse, neglect, or exploitation) in the community in a variety of settings, experts agree that these reports represent only the tip of the iceberg and that elder abuse and neglect remain greatly hidden problems.

Elders in the community often experience the deterioration of their social network that may contribute to cognitive and functional decline [3], factors that have been linked to elder abuse and neglect in the community. The National Elder Abuse Incidence Study found that elders unable to care for themselves were at greater risk of experiencing abuse; approximately 60% of victims whose abuse was substantiated had some degree of mental impairment. Other risk factors for abuse and neglect in the community include poor social functioning as

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manifested by expressions of conflict with family or friends, social isolation, alcohol abuse, and psychiatric illness [4].

In the majority of states, health care professionals, such as licensed or registered nurses, physicians, and nurse's aides, are mandated reporters of elder abuse and neglect. Although physicians report only 0.6% to 2% of cases and nonphysician health care professionals report 11% to 26% of cases [5,6], physicians and other health care professionals are in a unique position to detect elder abuse and neglect and assess for the physical, mental, and medical needs of the elderly person. Physicians and other health care professionals are often the only noncaregivers with whom an older person has contact. Elder abuse and neglect often go undetected because of a lack of knowledge, denial of the problem, confounding problems related to aging, and the absence of uniform definitions [5].

Caring for elders living in the community who are abused or neglected requires collaboration of professionals from diverse disciplines. Elder abuse and neglect cases often pose multiple, complex issues that may be social, medical, ethical, legal, and financial in nature and that require expertise beyond that available from any single discipline [7]. Therefore, an interdisciplinary team effort is needed to effectively manage them. Depending on the type and work of the team, members may include a variety of professionals, such as physicians, nurses, social workers, APS caseworkers, law enforcement personnel, prosecutors, clergy, and representatives from financial institutions.

In this article, we discuss several types of teams and the issues they encounter when managing elder abuse and neglect in the community. The teams that are described include medical case management teams that focus on the medical and social aspects, legal intervention teams that address criminal and civil case development and the special legal and ethical issues that frequently arise, and APS teams that advocate for the elder's autonomy and liaise between elders in the community and services available to assist them. We discuss other specialized teams including the Fiduciary Abuse Specialist Teams (FAST) and Fatality Review teams (FRTs). We then discuss how a medical practitioner can respond to cases of elder abuse and neglect and the multiples resources available for elders in the community.

### **Duty to report**

Although physicians have long been familiar with child abuse reporting requirements, the duty to report suspected elder abuse to legal entities is much less familiar. Medical ethics require that care be rendered to persons whether they abide by or break the law [8]. For the most part, patient-physician communications are considered confidential and not discoverable. Every state has a designated protective services agency to receive reports and assist older or vulnerable or frail adults. In all but six states (New York, Delaware, Wisconsin,

Colorado, and South Dakota) [6], physicians must report cases of elder mistreatment to these agencies. Although in 16 states, every citizen is a mandatory reporter [6], mandatory reporting laws generally apply to professionals who routinely encounter vulnerable populations, such as medical, mental health, social service, and law enforcement personnel. In addition, every state provides for permissive reporting of suspected abuse or neglect by anyone. Although the specifics of reporting laws vary from state to state, failure to report is a punishable offense in 42 states [6]. Statutes are intended to encourage reporting, and, therefore, good faith reporters are immune from civil and criminal lawsuits. Protective services agencies must keep the identity of the reporter confidential.

Reporting allows states to measure the extent of the problem, to offer services to at-risk adults, to tailor delivery of social services to the needs of its citizens, and to identify and track perpetrators. The reportable conduct does not have to be criminal, and in most cases no criminal conduct has occurred. Most importantly, reporting provides access to a host of services that would not otherwise be available. These services are directly provided by or secured by caseworkers of APS agencies.

## **Adult protective services**

### *History*

Protective service agencies, including APS, are the public organizations responsible for investigating allegations of abuse, neglect, and exploitation of elderly and disabled adults. The problem of elder abuse in the community gained early recognition in the 1960s. A few states and local social service agencies began limited efforts to address it. The first federal government measures to address elder abuse came in Title XX of the Social Security Act of 1974. The Act gave individual states authorization to use Social Service Block Grant funds to protect the elderly persons in addition to children [9].

Although Title XX allowed individual protective service programs to expand, subsequent federal funding has failed to ensure adequate monies and legislation to allow APS programs to become uniform and well funded. APS programs often fall under the same agency umbrellas as Child Protective Services (CPS) and are forced to compete with CPS for funding and resources. APS does not receive the attention and community awareness that CPS commands. According to a 2002 white paper by the Senate Special Committee on Aging, federal funding appropriated for elder abuse totaled \$153 million dollars; \$520 million dollars were expended on violence against women programs; and \$6.7 billion dollars were spent on child abuse prevention programs [9].

With minimal federal funding provided to support elder protective services programs, the states have had to appropriate money to fund these programs. The

result has been wide variation in APS programs across the country. APS programs have differing policies, procedures, resources, and staffing. Agencies may be administered at the state, county, or local level.

All APS programs operate under the same philosophic principles. Core principles include advocating for each individual's constitutional right to autonomy, preserving the rights of individuals with capacity to make their own decisions, and selecting the least restrictive alternative among service options. The preservation of the family unit is also a priority. APS casework usually consists of case investigation, substantiation of one or more allegations, and intervention.

### *Adult Protective Services investigation*

APS workers must depend on persons in the community to bring cases of abuse, neglect, or exploitation to their attention. Although there are legal protections for reporters, many cases are not reported. According to the National Elder Abuse Incidence Study [1], for every reported incident of elder abuse, neglect, exploitation, or self-neglect, approximately five are unreported. Most reports are of suspected self-neglect. Some of the reasons for failure to report include the lack of awareness of the existence or capabilities of APS, belief that reporting will compromise their relationship with the patient's family and that nothing will be done to improve the situation, fear of state involvement in the matter, concern that the reporter will face retaliation from the alleged perpetrator, and the desire to avoid the court process.

APS investigations are initiated by reports and proceed according to different policy-driven response times. An "emergency case," where there is an immediate danger to life and health, is ordinarily addressed within hours to a day. In non-emergency cases, and depending on the program, investigations begin anywhere from 1 to 14 days after the report is received. Some APS programs have 24-hour call centers and on-call staff. In other programs, the police or the emergency department staff address immediate needs until protective service workers can be contacted on the next business day.

Investigations include an interview with the client. In most states, APS workers are directed to attempt to interview the alleged perpetrator. They contact collateral sources for additional information about the client, including Social Security personnel, mental health professionals, primary care physicians, home health staff, family, friends, neighbors, financial institutions, and law enforcement. APS staff obtains and uses photographs of bruises/markings, hospital records, police reports, bank statements, canceled checks, and other forms of documentation as part of their investigations.

Confidentiality often is an obstacle for caseworkers attempting to obtain health and financial information. The recent Health Information Portability Accountability Act (HIPAA) has made obtaining information more difficult for APS caseworkers. Many states have statutes that mandate release of information and records to APS to assist them in their investigations. HIPAA regulations do

not overturn existing state and federal laws, but confusion over HIPAA and its applications have meant that some organizations that should be providing records to APS are failing to do so.

### *Case substantiation*

Workers usually have between 30 and 60 days to complete an investigation and determine the validity of an allegation. APS workers deem cases substantiated, unsubstantiated, or indeterminate. Some states require a preponderance of evidence standard to substantiate a case, whereas others require a higher degree of proof. At times there is limited objective evidence to support an allegation; workers must often weigh one person's word against another's and assess the credibility of those interviewed. Sometime there are not enough objective findings to make a determination. Cases are considered indeterminate when there is not enough evidence to prove or disprove the allegation.

At times, cases are not substantiated. In a small number of cases, the data collected do not support the allegation. On occasion, a false report is made, usually to embarrass or exact revenge on the client or the alleged perpetrator. This is not only a serious misuse of community resources, but in some states it is also a crime. Unsubstantiated cases are closed.

In a survey of state APS programs, performed by the National Association of Adult Protective Service Administrators, 41 states responded to a question concerning substantiation rates. The mean substantiation rate was calculated to be 48.4% and ranged from 2.2% in Florida to 100% in Indiana [6]. This wide variation may be due to differing definitions of a substantiated case and criteria for case investigation. After substantiation, caseworkers can develop intervention plans for their clients.

### *Adult Protective Service intervention*

APS caseworkers can marshal a number of services to address client neglect, abuse, and other mistreatment. APS services are voluntary, and the client has the right to accept or decline them. APS interventions can be grouped into the following categories:

- Arranging for housing services, including emergency housing, cleaning services, home repairs, and home modification to meet the needs of persons with disabilities
- Obtaining medical services, including temporary medications, referral to health care for assessments, and assisting with application for health care benefits
- Addressing personal needs, including obtaining food delivery, applying for food stamps, and securing caretaker or other provider services
- Providing service coordination, such as short-term case management, providing linkage to other service groups

- Serving as a client advocate when family members are unavailable to interact with health professionals or make application for community programs
- Implementing legal interventions, such as guardianship, involuntary mental health commitments, and emergency removals (referred to differently depending on the state)

Legal interventions are the most restrictive actions an APS worker can use. They are used only when all other less restrictive alternatives have failed or are clearly inappropriate. Although there is variation between states regarding available legal options, typically each requires the involvement of medical practitioners before or after the initial action is taken. Physicians are often involved when an adult's decision-making capacity is an issue. Questions may arise when a client refuses needed services or remains in unsafe situations. APS seek the assistance of an agency attorney to bring the matter to the attention of the local court where the judge decides the person's legal competency.

If adults suffering from mental illness or cognitive impairment are at immediate risk of hurting themselves or others or require medical attention but have refused to receive it because they lack capacity to understand the consequence of the decision, APS caseworkers can obtain mental health warrants or emergency removal orders. Emergency removal orders (the name for this varies from state to state) usually require judicial approval and authorize temporary involuntary admission into a psychiatric or medical hospital. The implementation of either of these frequently results in the ultimate pursuit of legal guardianship.

Legal guardianship (also called conservatorship in a few states) is the permanent removal of a person's right to make his or her own decisions. It is implemented in situations where clients are no longer able to manage their personal or financial affairs and have not designated a surrogate decision maker. Although it is the most restrictive alternative, its requirements of judicial involvement and oversight and due process protections for wards and conservatees are intended to reduce opportunities for misuse and abuse [10]. Where guardians are needed but no responsible family members or friends are available, in some state or regions, APS workers assume this role. In other sites, social services caseworkers, private guardians and conservators, public guardians, or lawyers may be appointed. Usually, a guardianship results in placement in a facility setting due to supervision requirements or medical condition that prompted the APS worker to seek guardianship in the first place.

### *Myths and misperceptions about Adult Protective Services*

Although caseworkers conduct investigations, APS has no law enforcement authority. Some equate APS workers with hospital social workers, but not all APS workers are social workers, and not all have bachelor's degrees. There is a fear that APS involvement always results in the removal of older persons from

their homes and their placement in institutions. Legal interventions are used in only 7% of cases nationally. Some believe that APS workers can force nonadherent clients to accept services. However, as agents of the state their authority is defined by statute, and under existing laws, APS workers cannot impose interventions on persons with the capacity to make decisions.

### *The need for multidisciplinary collaborations*

A critical issue facing protective services and its ability to impose services and interventions on an unwilling adult is a determination of his or her decision-making capacity. Although the APS caseworker is charged with assessing capacity, there are no validated and reliable instruments designed for use by nonmedical professionals. When APS workers suspect that a client lacks capacity, they must determine if the client understands the consequences of their decisions. Workers must evaluate if there are any indications of mental illness, dementia, or other cognitive impairment, notwithstanding the reality that persons with early and even moderate dementia have preserved social skills that make it especially difficult to accurately assess their capacity [11–13]. Some persons, especially those with high intelligent quotients or who are highly educated, maintain excellent verbal skills while lacking insight, good judgment, or the physical ability to care for themselves in a safe manner. In such “gray” cases, the determination of capacity can be difficult for highly trained and skilled physicians. Such determinations are fraught with difficulties for APS workers who are differently skilled and trained.

Medically based community resources, such as medical case management teams (described below), are essential to making such determinations and providing good care to clients [14]. Where available, APS staff turn to geriatricians, generalists, psychiatrists, or other medical professionals to formally assess the client’s ability to understand the consequences of decisions and to advise in diagnosing and treating existing medical conditions. In some communities, qualified and willing medical experts to assess capacity are not always available, so APS must make these difficult assessments without them.

The rest of this article addresses the many disciplines that interact with mistreated elders and the formal and informal community-based collaborations that have formed to better identify, intervene, and prevent elder abuse.

### **Medical case management teams**

For the last 20 years, geriatricians and gerontologists have been performing comprehensive geriatric assessment (CGA) and intervention in their frail patients. CGA includes assessments of social situation, functional status, and health [15,16]. CGA uses an interdisciplinary approach because members of no single discipline possess all the skills required to meet the needs of frail older persons. Numerous studies have demonstrated the benefits of CGA and intervention to

hospitalized, institutionalized, and community-dwelling elders [17–19]. It is not surprising, then, that this interdisciplinary approach would be applied to mistreated elders who are frail and also vulnerable.

### *History*

In response to a Massachusetts law enacted in 1980, a medical interdisciplinary case management team was formed at the Beth Israel Hospital in Massachusetts. The purpose of this team is to provide consultation and support to hospital staff, assist in a multidimensional evaluation of older patients where abuse is suspected, and develop treatment plans. The team, composed of a physician, nurses, and social workers, meets weekly to discuss referred cases. The team also educates hospital staff about identification and intervention in elder abuse [20]. Another hospital-based team formed in the 1998 at Mount Sinai Hospital in New York to detect elder mistreatment in hospitalized patients and “. . .to assist them in attaining compensation, and to provide counseling, support, advocacy and referral” [21].

Physicians and medical teams throughout the United States have been and are informally collaborating with APS in their communities. In the mid-1990s, geriatric medicine teams began to formally collaborate with Adult Protective Services at Baylor College of Medicine in Houston, Texas, at the University of California at Irvine in Orange County, at the Robert Wood Johnson Medical School in New Jersey, and at Hennepin Medical Center in Minnesota [22]. These teams address all forms of elder abuse and self-neglect. Although each educates trainees from a variety of disciplines about elder abuse intervention, differences in setting, funding, and the local needs of APS make each team unique.

The medical case management team generally cares for the more medically complex victims, especially self-neglectors. This team usually operates within a health care system and draws on the expertise of a full range of medical specialists. Its membership looks like a geriatric interdisciplinary team, with members from geriatric medicine, nursing, social work, and other health care fields, but also includes APS workers and may include law enforcement officers, attorneys, and victim advocates. Often ethicists, forensic psychiatrists, and members of other medical disciplines are called to provide consultation.

### *The work of the medical case management team*

The medical case management team generally receives referrals from APS, although law enforcement, medical examiners, prosecutors, and others may refer cases. Despite variation in local needs and the capabilities and interests of members, the work of these teams is similar and usually takes place in three phases. The first phase is the investigation or assessment that a member from the referring agency performs. In the next phase, a comprehensive geriatric assessment is conducted by the medical team, and assessment or investigations as needed are undertaken by team members from other disciplines. The third phase

is the interdisciplinary team meeting, where all the participating members craft a joint intervention plan. In the same way that interdisciplinary geriatric medicine case conferences help team members learn about each other’s disciplines, divides the work, prevents duplication of effort, and enables the development of innovative and effective care plans, so do elder mistreatment medical case management teams provide benefit to patients, the participants, and their organizations. Finally, the intervention plan is performed (Fig. 1).

*Assessment*

*House calls.* House calls are often a major function of elder mistreatment case management teams in situations where patients refuse to leave their homes. These patients may be fearful, ashamed of their circumstances, or unable to physically leave the dwelling, and a house call may be the only way for that patient to receive care. House calls afford the clinician a clearer view of how the patient functions in his or her own environment and makes detection of some forms of abuse, such as self-neglect or financial exploitation, easier. The diagnosis of hoarding or Diogenes syndrome, an extreme form of self-neglect, is diagnosed by visual inspection of the patient’s living situation.

*Common diagnoses.* The medical team performs a comprehensive geriatric assessment regardless of the setting where the evaluation takes place. Victims of elder mistreatment and self-neglect most often are diagnosed with dementia, depression, psychosis, alcohol abuse, and loss of executive function [23–25]. Much of the work of the medical case management team involves assessment and intervention on behalf of patients who are experiencing cognitive decline

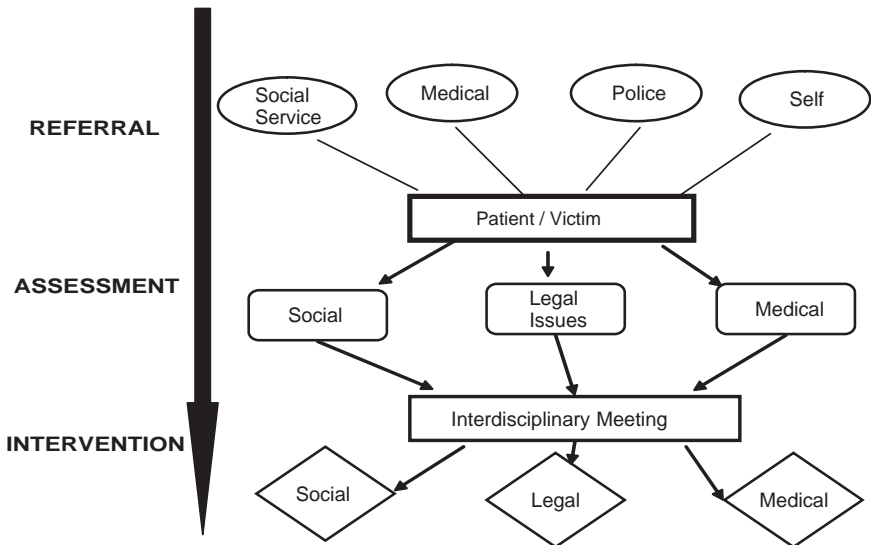


Fig.1. Sample medical case management team process.

leading to frailty and the inability to provide their own care. In some cases, cognitive decline affects the patient's judgment, resulting in their refusal of much-needed APS or medical interventions. Because APS workers are guided by the principle of self-determination and have different expertise from health care professionals, they may be persuaded by articulate or impassioned pleas of clients who wish to remain in questionable situations. It is in these cases that the physician's expertise in assessing decision-making capacity is critical to the team's evaluation.

*Case management team interventions.* After multidimensional comprehensive geriatric assessment, the interdisciplinary team members meet for case review. The group discusses the diagnoses or findings determined from the comprehensive evaluation. The members then craft appropriate intervention plans. Patients suffering from physical abuse receive treatment for their injuries. Self-neglectors or victims of caregiver neglect may (and frequently do) require intervention for neurocognitive or affective disorders. Treatment is provided for any identified reversible disorders. Physical and occupational therapists may treat to restore function. The medical professionals work with members of the team from various disciplines to craft comprehensive interventions plans and jointly participate in decisions regarding living situations. Medical case management team interventions include the following:

- Treating or curing disease states. These teams work to improve cognitive status by providing medication and mental retraining, improve functional status by prescribing therapy or assistive devices, treat behavioral disorders with appropriate medical and environmental modifications, and adjust/monitor complex medication regimens.
- Prevention of deterioration by monitoring health status and responding to acute physical and mental changes, improving nutrition, and recommending appropriate modifications to living situations
- Educating patients about their disease states and requirements for improved health and training caregivers
- Providing palliative care at the end of life by controlling pain and symptoms

Finally, on occasion medical examiners, physicians, nurses, and other health professionals may be needed to offer expert testimony in criminal and civil proceedings.

### **Legal intervention teams**

Although APS agencies address the social and functional issues faced by mistreated elders and medical case management teams address health, function, and social issues, it is the justice system that must address the legal concerns. Mistreated elders may be victims of physical abuse, criminal neglect, sexual

assault, and intimate partner violence, and they need protection. Experts to address financial management, probate and guardianships, other legal issues, housing, and more are needed. Specialized teams exist to deal with these serious legal issues.

### *The criminal justice system*

The criminal justice system includes law enforcement officers and prosecutors. Its role is to stop criminal conduct, protect individual victims and society from criminal acts, hold offenders accountable, make victims whole by restoring their personal losses, and rehabilitate perpetrators [26]. The role of law enforcement in elder abuse is assessment, enforcement, support, and referral [27]. Law enforcement officers conduct investigations, determine if crimes have occurred, interview witnesses, collect evidence, and, when appropriate, make arrests. The prosecution function focuses on deciding whether to bring criminal charges and the presentation of cases in court, including the production of witnesses and evidence and sentencing recommendations [28]. Criminal justice interventions include the following:

- Holding offenders accountable by initiating charges, prosecuting cases on behalf of the community, prosecution and law enforcement working together during investigations, seeking increased bail or remand, conducting grand jury investigations, issuing subpoenas, and obtaining convictions, seeking case appropriate conditions of probation, and filing motions seeking sanctions for violations of probation or failure to pay restitution
- Assisting victims by providing information about the legal system, obtaining court orders, seeking orders of restitution, presenting victim impact information at sentencing, and appearing at parole hearings to resist early release
- Responding to crime reports by collecting evidence, conducting forensic evidence examinations, identifying perpetrators, and arresting offenders
- Obtaining court orders, such as arrest and search warrants, and other orders to protect victims (where permitted)
- Increasing safety by seizure of weapons, performing welfare checks, and accompanying various professionals and team members on house calls/home visits
- Obtaining medical assistance for injured or ill victims and psychiatric care for mentally disturbed persons

### *Criminal prosecution teams*

There are a variety of criminal justice teams operating throughout the United States. These can be led by law enforcement, such as domestic violence response teams in which an officer works with a victim advocate to respond to cases of domestic violence, including cases involving elderly parties. The officer

investigates crimes, collects evidence, and develops cases for possible prosecution while the advocate meets with the victim to address his or her immediate safety and other concerns. In Rapid Response Teams, investigators from a law enforcement agency or prosecutors office respond with APS caseworkers to reports of elder abuse. The caseworker investigates allegations of abuse and focuses on client needs and substantiation of elder abuse allegations while the investigator attempts to determine if a crime has occurred and, if so, to protect and secure remaining victim assets.

In some communities, the prosecutor works with various professionals and, upon receipt of a report of possible elder abuse, selects appropriate team members to investigate the matter and build the case for prosecution. One such team operates in the United States' Attorney's Office in Washington, DC. In other prosecutors offices, significant prosecution units have been created. These work closely with a variety of professionals including law enforcement, APS, health care providers, and others to address elder abuse allegations [29,30].

### *The civil justice system*

Members of the civil justice system, including family, estate planning, tax, and probate lawyers, can pursue an array of legal remedies aimed at protecting victims, securing and restoring assets, assessing responsibility, and appointing surrogate decision makers. In the elder abuse arena, civil courts can issue a variety of protective orders, adjudicate lawsuits, issue emergency removal orders, order involuntary mental health placements, create guardianships, secure accountings, and order assets be frozen to protect remaining assets and estates.

Civil justice interventions include the following:

- Seeking court orders and guardianships to protect clients
- Initiating lawsuits on behalf of clients for such causes of action as theft, assault and battery, conversion, breach of contract, and negligence
- Advanced planning, including powers of attorney and trust

### *Fiduciary Abuse Specialist Teams*

FASTs are an example of a civil justice–focused team; the purpose of a FAST is to develop financial exploitation cases. Teams are staffed by law enforcement officers, prosecutors, private and public interest attorneys, public and private conservators, bankers, securities and real estate brokers, APS workers, members of the Long Term Care Ombudsman Program, and experts in finances, insurance, care management, probate, gerontology, geriatrics, and psychiatry [31]. These partnerships of professionals volunteer their time to review cases and facilitate comprehensive service delivery [32]. The first FAST was established in Los Angeles County in 1993 [33].

As the benefits of the model have been identified, other FASTs have been created so that there are teams operating throughout California, parts of Oregon,

and elsewhere. An innovative aspect of the Oregon team is its recruitment of volunteer, retired employees of financial institutions and analysts to analyze evidence and assist law enforcement and prosecutors in building financial exploitation criminal cases. Teams may also advocate for legislative reform, educate the community, and train professionals [32].

### **Other community-based approaches**

Other types of collaborations have evolved to address different aspects of elder mistreatment. These include code enforcement teams, fatality review teams, and victim advocacy programs. Medical professionals can participate in any of these teams.

#### *Code enforcement team*

Code enforcement teams inspect locations and facilities where there are reported public nuisances or recurring reports of inadequate care. Team membership is drawn from regulatory and licensing agencies, law enforcement, fire services, pest control authorities, building inspectors, and investigators from offices of state attorneys general, city attorneys, and county counsel. Drawing on the expertise and authority of many officials, teams conduct unannounced inspections to identify dangerous, illegal, or unsanitary sites. If needed, they pursue administrative and licensing actions or file civil or criminal lawsuits to obtain improvements, clean up problematic locations, seek changes in procedures or management, or secure the closure of a facility. Teams may operate at the local or state level. Examples of state-level teams are those in Offices of the Attorney General in California and Florida that inspect problematic elder care facilities.

#### *Fatality review teams*

Elder abuse FRTs, a recent development in elder abuse, are often modeled on child and domestic violence death review teams. Their role is to review deaths of older persons that are believed to have resulted from elder abuse to assess systemic responses, such as problems with service delivery, and identify prevention strategies [31]. Some FRTs review cases to determine if prosecution should be considered. This team requires participation by the medical examiner or coroner. FRTs may recommend legislative changes, adoption of new policies by agencies, and elder abuse training. These teams operate in various locations across the country, including San Diego, Sacramento, and Orange County, California; Harris County, Texas; and Portland, Maine.

#### *Victim advocacy organizations*

Advocacy is an encompassing term that covers many different private and public agencies and organizations that serve victims of abuse and mistreatment.

Some organizations assist victims of domestic violence and sexual assault. Some serve elder abuse victims, and some serve all crime victims. Advocates may be community based or part of victim-witness assistance program associated with the criminal justice system. Many have special legally protected confidential relationships with their clients. Their services are voluntary and generally operate on an empowerment model in which programs and resources are offered to a victim who decides which, if any, are appropriate for his or her situation. Available services may include providing legal advocacy and assistance; helping with emergency shelter and new housing; obtaining health care services; coordinating support groups; applying for financial benefits; obtaining other emergency and longer-term services; and assisting with recovery from the physical, emotional, and financial effects of their victimizations.

### **How the practitioner can respond**

With the range of possible interventions and the complex client needs that must be met by medical and legal professionals and others, collaboration with other disciplines may be more effective. The following is a case example of how an interdisciplinary medical case management team handles a case of caregiver neglect.

A 77-year-old woman, Mrs. R.L. was released from the hospital after intravenous treatment of lower extremity cellulitis; lacerations caused by her pet cat had become infected. She was also diagnosed with hypothyroidism and was begun on replacement therapy. At discharge, the physician wrote orders for a home health nurse to visit the patient.

Two days after discharge, the nurse went to Mrs. R.L.'s home and discovered the patient's home piled high with trash and rotting food. There were 10 cats roaming the premises. During an examination, the nurse met the patient's son who was intoxicated and shouting from his bedroom. The patient was lying in a bed without a sheet, wearing a soiled diaper and urine-soaked clothing. The nurse called the physician and reported the case to APS.

An APS caseworker went to Mrs. R.L.'s home the next day and confirmed that the environment was unclean and unsafe and that the patient was being neglected. The patient's son was threatening to the worker and was concerned that his mother would be removed from her home. The APS worker found evidence that the son was cashing Mrs. R.L.'s social security checks and using them to buy alcohol. The APS worker spoke to the neighbors who told her that Mrs. R.L.'s son had recently been incarcerated for assault with a deadly weapon. The neighbor confirmed that the son often yelled at his mother and threatened to leave her.

APS substantiated two allegations: caregiver neglect and financial exploitation. They consulted the medical elder abuse team in their community and requested that they make a house call to evaluate the patient. The team carefully

orchestrated the house call. Based on the history of a threatening son, the medical team called the police and requested that an officer accompany them on the visit. The protective services lawyer was notified that an emergency removal order might be needed. A social worker and physician from the medical team went to Mrs. R.L.'s home and verified the nurse's findings. In addition, they discovered that the patient had multiple flea bites, was lethargic, and had a temperature of 95.7°F. Her mini-mental state score was 20, and the Confusion Assessment Method test was positive for delirium. The team suspected that the patient had hypothyroidism and informed the patient that she needed to go to a hospital for immediate attention. When the physician spoke to the patient and provided a detailed explanation of the risks of not being treated, the patient refused hospitalization.

The medical team contacted the APS attorney and indicated that Mrs. R.L. required emergency medical treatment. The attorney obtained a court order for Mrs. R.L.'s emergency removal from her home. Paramedics were called to transport her to the hospital where she was diagnosed with a urinary tract infection and a markedly elevated thyroid stimulating hormone. After treatment, her mental status improved (MMSE of 25). She acknowledged that her son had a drinking problem but asked to return to her home to live with him. The medical team suspected that she had diminished decision-making capacity; this finding was confirmed by neuropsychologic testing.

An interdisciplinary team meeting was held. The APS worker reported that she had located the patient's daughter who was living out of state. Once informed of her mother's situation, the daughter was willing to become her mother's guardian. She asked that Mrs. R.L. move into her home. The physician, social workers, and nurses agreed that the patient would be safe in the community in her daughter's home and did not require nursing home placement. The patient's daughter applied to become her mother's guardian, and, over the son's opposition, the judge granted custody to the daughter. The son was arrested on a parole violation when a gun was found in the home by police officers; he is now incarcerated. His mother lives in a comfortable home and is receiving the medical care she needs.

This case is an illustration of how an interdisciplinary collaboration can be effective in a difficult and complex situation. The APS worker, police officers, physician, nurses, social workers, paramedics, a lawyer, and a judge participated in the intervention. The interdisciplinary team was able to coordinate a multiphase intervention that achieved the overarching goals of stopping the abuse, holding the offender accountable, improving the quality of life for the victim, and protecting the local community from the abusive son.

The involvement of these and other systems was necessary because cases like this are so complex and multifaceted that the response of a single system is not effective in addressing the problem. In the same way that geriatric teams evolved to meet the complex needs of frail elders, multidisciplinary elder mistreatment intervention teams have evolved to provide more comprehensive and effective interventions.

## Other resources

In addition to protective service workers, medical professionals, and members of the civil and criminal justice systems, the assistance of members from other disciplines is required to design the most appropriate intervention plan. Professionals from a variety of community-based agencies can contribute to the work of elder mistreatment teams. They bring their unique perspectives and may offer different interventions. They can serve as resource personnel and are often asked to participate in the types of teams described previously on continuing or ad hoc bases. Some of the resources that may be helpful to elder mistreatment casework in the community described below.

Area Agencies on Aging were established under the Older Americans Act in 1973 and are located in every community. They provide a host of services that would be helpful in developing intervention plans. They provide information and access services (eg, health insurance counseling), community-based services (eg, adult day care), in-home services (eg, homemakers and Meals-on-Wheels), assistance with housing (eg, locating assisted living facilities or foster care), and support of elder rights (eg, legal assistance) [34].

Local women's shelters or centers house experts in the intervention of domestic violence and intimate partner violence involving younger women. Some centers may have staff with the expertise to deal with these same problems in elderly patients. Alternatively, the center staff could work with a medical case management team to adapt the techniques known to help younger women to the needs of older patients. Domestic violence intervention in elderly persons requires a specialized approach, and members of a medical case management teams may want to consult experts before proceeding.

The National Center for Elder Abuse (NCEA) is funded through the Administration on Aging [35]. They have a wealth of resources including national and state statistics. They have a training library and track elder mistreatment educational conferences for the entire United States. They have commissioned several studies, and two recent documents could be helpful to in communities that are developing or wish to develop a community-based response to elder mistreatment. They are "A National Look at Multidisciplinary Teams" [33] and Multidisciplinary Elder Abuse Prevention Teams: A New Generation [31].

The Clearinghouse for Abuse Neglect of the Elderly (CANE) is located at the University of Delaware and is funded by the NCEA. This archive is the nation's largest and includes published research, training resources, government documents, and other sources on elder abuse. The CANE collection is computerized, and interested parties can perform text searches. CANE has nearly 5000 holdings. The staff has compiled 12 bibliography series with annotated references; of particular interest is the series entitled "The Health Care System: Addressing Elder Mistreatment from July 2003" [36].

The National Clearinghouse on Abuse in Late Life was established by the Wisconsin Coalition Against Domestic Violence in 1999 with funding from the

Department of Justice's Office on Violence Against Women. The staff of this national organization has expertise in program development, policy and technical assistance, and training. They have assembled a directory of services that "contains nationwide resources, state domestic violence coalitions, state sexual assault coalitions, state adult protective services offices, elder shelters and support groups tailored to older women" [37].

The American Bar Association Commission on Law and Aging features a host of resources including legal guides, online brochures, and toolkits. Their literature provides advice to consumers and lawyers. This group cosponsors the National Law and Aging conference and has expertise in a number of issues, including planning for incapacity, guardianship, elder abuse, health care decision-making, pain management, and end-of-life care [38].

## Summary

The role of medical professionals who address community elder abuse, like that for treating patients in hospitals or other outpatient settings, is to screen for elder mistreatment, diagnose overt or underlying disease states, and provide appropriate treatment while considering the patient's medical, social, functional, financial, and legal needs. This requires heightened awareness of elder mistreatment; knowledge of the historic and physical findings; ascertainment of collateral history; complete documentation of findings; and collaboration with members of other disciplines, including law and protective service. Physicians and other medical professionals, especially members of geriatric interdisciplinary teams, are well suited to collaborate and develop case management teams. Medical professionals can provide clinical care while training others and conducting research.

A number of elder mistreatment team models have formed. Their precise membership, focus, and goals vary based on the defined needs of the community in which they operate. Some focus on particular cases, whereas others review systems' responses to identify gaps in service and system weaknesses. Geriatricians and other gerontology professionals serve on all these teams. Elder abuse is a complex and multifaceted problem whose impact is felt by many different systems. Victims and their families frequently are served by multiple systems simultaneously. Systems responses may be inconsistent, philosophically at odds, and not comprehensive, but an effective intervention must recognize and understand other potential involved systems may be and what they do. In some places, the medical professional can play a critical role in improving their own and other systems' responses in an elder abuse matter.

Just as pediatricians championed the fight against child abuse in 1970s and 1980s, so can geriatricians and all health professionals who care for older persons become champions in the twenty-first century's fight against elder mistreatment.

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