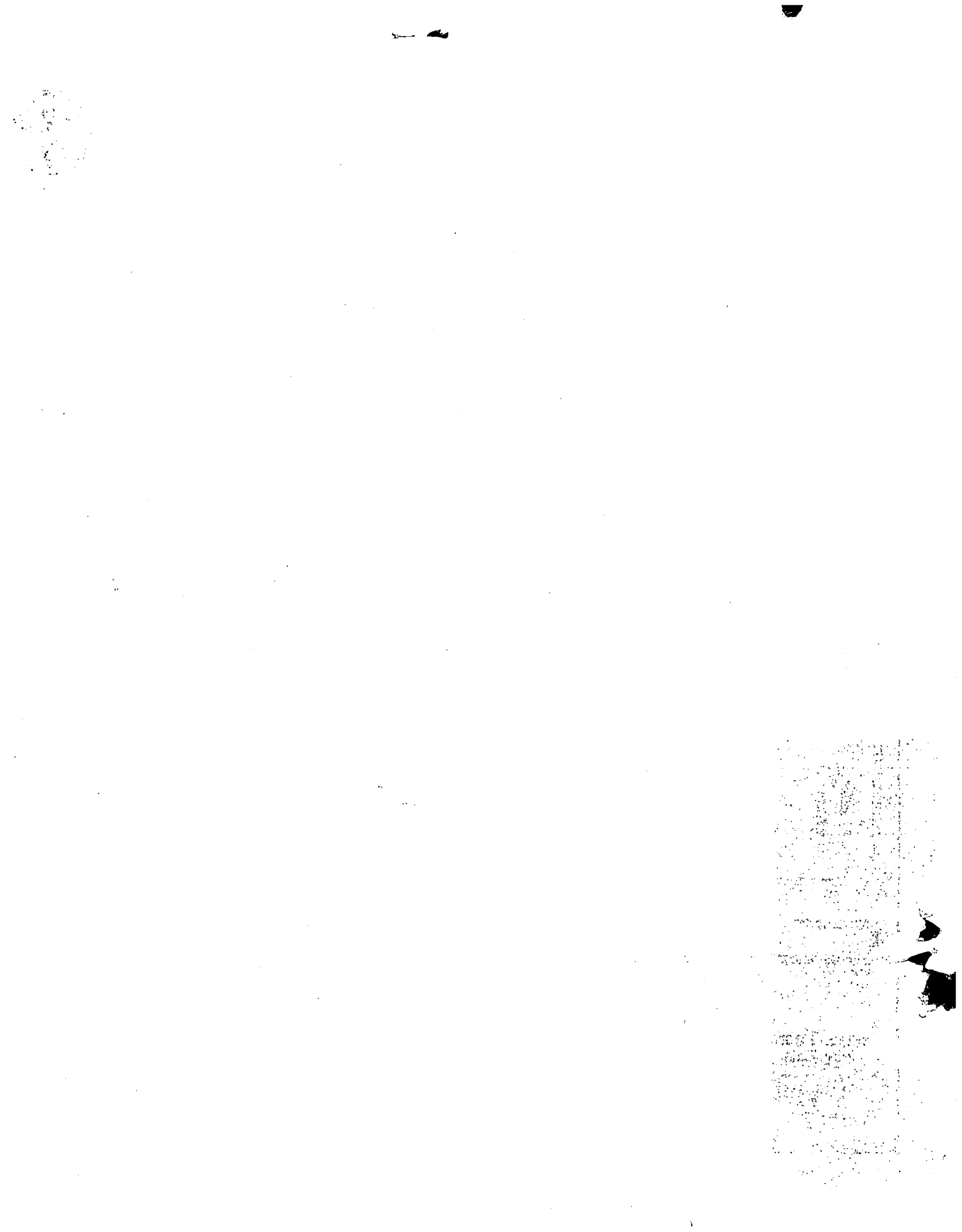
Elder Abuse and Neglect: A Guide for Practitioners and Policy Makers

National Paralegal Inst.
San Francisco, CA

Prepared for

Oregon Dept. of Human Resources, Salem

Feb 81



ELDER ABUSE AND NEGLECT: A GUIDE FOR PRACTITIONERS AND POLICY MAKERS

PREPARED FOR THE OREGON OFFICE OF ELDERLY AFFAIRS

BY
The National Paralegal Institute
San Francisco, California

WITH
Legal Research and Services
for the Elderly
Boston, Massachusetts

February 1981

This manual was prepared by the National Paralegal Institute, San Francisco, California, under Contract No. 14-035-01 from the Oregon Office of Elderly Affairs. Its contents are solely the responsibility of the editors and do not necessarily reflect positions or policies of the Oregon Office of Elderly Affairs.

DOCUMENT INFORMATION SHEET

REPORT NUMBER
SHR-0009295

TITLE
Elder Abuse and Neglect: A Guide for Practitioners and Policy Makers.

REPORT DATE
Feb 81

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PERFORMING ORGANIZATION, NUMBER & NAME
National Paralegal Inst., San Francisco, CA.

SPONSORING ORGANIZATION
Oregon Dept. of Human Resources, Salem. Office of Elderly Affairs.

AVAILABILITY
UNLIMITED

PAGES
0180p

PRICE
PC A09/MF A01

ELDER ABUSE AND NEGLECT: A GUIDE FOR PRACTITIONERS AND POLICY MAKERS

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12 APR 1982

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Acknowledgements

The editors wish to thank Robert Zeigen, Administrator of the Oregon Office of Elderly Affairs, for supporting the preparation of a manual designed both to assist Oregon and to serve as a model for other states. We also extend thanks to Georgena Dutton, our Project Officer, for her practical guidance and good humor.

We wish to give recognition to Chisato Kawabori, Regional Program Director, Administration on Aging, Region X, for his pioneering efforts to develop effective responses to elder abuse and to Ruth Ward, Aging Specialist in the Region X office, for her work in pursuing cooperation among federal and state agencies.

Special credit goes to Jane Hultman for organizing the preparation of the manuscript and to Marilyn Bennett, Cal Gough and Iris Turner for their diligent typing.

Preface

This manual attempts to provide an overview of elder abuse that is useful to both practitioners and policy makers. It reviews the current research; presents intervention strategies and protocols; discusses model delivery systems and legislation; and provides information and materials for practitioner training and public education.

Knowledge of the nature and causes of elder abuse is limited. Still less is known about treatment and prevention. This manual should be read not as a definitive statement but rather as a guide to the exploratory steps that have been taken in the field.

This manual is general in nature, except for the review of Oregon laws and resources in Part V. Any person or agency working with elder abuse in a state other than Oregon should have a comparable review prepared for that state.

CONTENTS

PART I:
ELDER ABUSE AND FAMILY VIOLENCE IN THE HOME:
A REVIEW OF THE RESEARCH

Old age is no guardian against the forces that breed violence in the home. Child abuse and spouse beating are now common knowledge, if their causes and cures are less well understood. Since the late 1970's a third form of family violence, no less shocking or socially damaging, has emerged into public consciousness: elder abuse. In its most flagrant and disturbing form, it consists of a dependent elderly parent "cared for" and battered in the home by a relative, often an adult child. Elder abuse is not a new phenomenon any more than child abuse or spouse beating. All three can be traced throughout history. What is new in America is the growing determination to examine these problems, even at the expense of lost illusions about our own innocence. Child abuse and spouse abuse have been documented, political action galvanized, and legislative reforms initiated. These are beginnings.

Now is the time to take similar steps to investigate and address elder abuse in its various forms. The victims and potential victims of elder abuse are an extremely vulnerable group, physically, psychologically and financially. They are comparatively powerless in our political system. Without improved understanding of their situation and a commitment by society to a wide range of assistance and reform, their vulnerability and suffering will continue.

CHAPTER 1

THE CURRENT RESEARCH ON ELDER ABUSE

Most of the information on elder abuse and neglect is contained in four research studies, all completed in the last two years. The following is a review and analysis of the findings.

1. Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals by Legal Research and Services for the Elderly.

The purpose of this survey conducted in March and April, 1979, was to gain descriptive information on the extent of the abuse of elders residing at home by their families, friends and other caretakers. Specifically, information was sought to answer the following questions:

- Which professionals encounter abuse?
- What are the characteristics of the abused and the abusers?
- What kinds of incidents occur?
- What responses are made by the helping professions?

For the purposes of the survey, abuse was defined as "the willful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker of services which are necessary to maintain mental and physical health."

Results are based on 332 responses to a survey of 1044 professionals and paraprofessionals. This is a response rate of 32%. Fifty-five percent (55%) of those responding cited an incident of elder abuse within the prior eighteen months. The majority of citings were reported by visiting nurses, hospital social service directors, and private social services agencies.

Physical trauma constituted over 41% of the reported injuries and included bruises, welts, cuts, punctures, bone fractures, dislocations, and burning. Other types of abuse less frequently reported included verbal harrassment, malnutrition, financial mismanagement, unreasonable confinement, over-sedation and sexual abuse.

The profile of the victim that emerged was that of a very old person (36% were over 80; 54% were over 75) with a significant physical or mental impairment (75%), female (80%) and living with the abuser

(75%) who was usually a family member (84%) and who abused the victim on a recurring basis (78%).

The abuser was most often a relative (86%) living with the victim (75%). Sons, husbands, and daughters were the largest categories of abusing relatives, accounting for 24%, 20%, and 15% of all abusers reported. The abuser was reported to be suffering some form of stress (74%), with alcohol and drug abuse cited most frequently (28%). The elder was judged to be a source of stress to the abuser (63%) due to the high level of physical and emotional care required of the abuser (48%).

Questions designed to yield information abut income level and incidence of other types of abuse in the family yielded unusable data.

Among the number of responses made by agencies encountering abuse, placement or attempts at placement of the victim ranked high. Where direct action was taken by an agency, placement was the single step most often taken or recommended (36%). When emergency action was taken, removal or recommended removal of the victim from the home was the course of action in over half the cases (56%).* When referrals were made, they were most often to social service agencies (48%), including mental health clinics, home care corporations, hospital social services, family services, visiting nurses, and public welfare agencies. Legal services represented 20% of all referrals.

Barriers to service provision were cited in 70% of the responses, particularly the refusal of the victim to acknowledge the problem or allow corrective action to be taken. In 45% of the citings, respondents indicated that the problem was resolved, although the responses tell little about the actual status of the abuse situation.

Main limitations of the survey:

- The sample was not random, and therefore the results cannot be generalized.
- The 183 citings do not necessarily represent 183 separate cases since respondents could have been reporting on the same case.
- Certain "opinion" information was requested.
- Responses based on memory as opposed to written cases were acceptable.

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*"Removal" refers to emergency intervention to take the elder out of the home/abuse situation temporarily. "Placement" refers to finding a long-term alternative living situation for the client.

2. Maryland: The Battered Elder Syndrome: An Exploratory Study by Marilyn Block and Jan D. Sinnott

The purposes of this study, conducted at the University of Maryland, were to make preliminary estimates of the prevalence of physical and psychological abuse of elders by their adult relatives, to develop a model describing different types of maltreatment and to test different research methods for feasibility, cost, adequacy and usefulness.

Four types of maltreatment are defined, which taken together, describe what the authors call the "battered elder syndrome". The four are:

- Physical abuse: malnutrition; injuries such as bruises, welts, sprains, dislocations, abrasions or lacerations.
- Psychological abuse: verbal assault, threat, fear and isolation.
- Material abuse: theft or misuse of money or property.
- Medical abuse: withholding of medications or aids required (e.g., false teeth, glasses, hearing aid).

The reported findings are based on a final sample of 26 cases: 4 from agency records, 3 from responses by a random sample of community-dwelling elders to a mail survey, and 19 from responses by individual professionals to a mail survey.

The profile of the abused that emerges from the data suggests that the abused elder is older than average (mean age: 84; range 60-92), female (81%), Protestant (61%), lower or middle class (15% and 58% respectively), and living with relatives (76%). Nearly half manifest a moderate or severe mental impairment and only 4% are free from physical impairments.

Nearly 80% of the abusers are relatives, primarily children of the victim (42%), who tend to be in their forties and fifties (53%). The majority are female (58%), white (88%), and middle class (65%). The abuse incidents were often repeated (58%) and were done more for psychological reasons (58%) than economic reasons (31%), according to respondents.

Results indicated that psychological abuse was more common than physical abuse. (The four separate behaviors identified under psychological abuse had frequent rates of 46%-58%). The most frequent types of physical abuse, lack of personal care and lack of supervision, both occurred in 38% of the cases. Beatings were cited in 15% of the cases.

Extrapolating from the data, Block estimates a national incidence of 4% of the elder population (or approximately one million victims), a figure comparable to the incidence of child abuse. Block concludes that elder abuse is similar to other forms of dependent abuse in that it is repetitive and committed by family members suffering from stress, especially economic stress. She contrasts it with other forms, however, by stating that the abused elders usually sought some form of help but were unable to find it. This would seem to suggest that learned helplessness is not a primary cause of elder abuse.

Response rates to survey questionnaires were low—negligible from agency records, slightly over 16% from community-dwelling elders and about 31% from individual professionals. Although the advantage of each method is explained, none is specifically recommended.

Major limitations of this study:

- The sample was very small and non-random, and therefore the results cannot be generalized.
- It is not clear that duplicate reporting of cases was eliminated.
- The survey asked for some information based on opinion, not fact. It is often difficult to judge the victim's financial status, reason for attack, and the extent to which action was taken. This also raises questions with respect to the middle class nature of abuse, the suffering of economic and psychological stress by the abuser, and the apparent refutation of learned helplessness as a factor in abuse.

3. Michigan: A Study of Maltreatment of the Elderly and Other Vulnerable Adults by Richard Douglass, Tom Hickey, and Catherine Noel.

The purposes of this study, conducted at the Institute of Gerontology and the School of Public Health at the University of Michigan, were to ascertain the extent of abuse and neglect of elders and other vulnerable adults, identify its characteristics, identify potential case finding procedures, and relate the findings of social etiology of these problems to the pychosocial literature on domestic violence. The year-long project was completed in November, 1979.

Personal interviews with 228 professionals in five community sites constituted the primary method of investigation for the domestic portion of the survey. An additional 36 interviews with staff of

12 nursing homes were conducted to form an institutional survey. Secondary data analyses were performed on nursing home intake forms for publicly supported clients in Michigan and on Detroit Police Department records of crimes against the elderly in 1978. The purpose of the former was to ascertain the extent of impairment and the potential for alternative care at home by families. The purpose of the latter was to determine the extent of criminal charges involving violence by family members toward elders.

A typology of maltreatment was developed with four categories:

- Passive Neglect: includes being ignored, left alone, isolated or forgotten.
- Active Neglect: includes having needed things withheld, such as companionship, medicine, food, exercise, or assistance to the bathroom.
- Verbal or Emotional Abuse: includes name calling, and being insulted, treated as a child, frightened, humiliated, intimidated, or threatened.
- Physical Abuse: includes being hit, slapped, bruised, sexually molested, cut, burned, or physically restrained.

Based on their interviews, the authors conclude that abuse and neglect of elders and other dependent adults by their caretakers does exist although it is not pervasive. Most prevalent, according to the sample, was passive neglect, followed by verbal and emotional abuse. Active neglect and physical abuse exist to a far lesser extent in the experience of community practitioners, although respondents in virtually every profession had some experience with explicit evidence of physical abuse.

Direct experience with particular types of abuse and neglect varies widely by profession. For example, familiarity with financial abuse was cited particularly by lawyers and judges while physical abuse was more likely to be encountered by caseworkers and mental health workers. Geographically, it appeared that reports of maltreatment were higher in urban/metropolitan areas, although it may be that the higher level of services available and the greater anonymity in an urban setting may lead to more adequate case recognition.

To elicit information about causality, practitioners were asked to select the most and least important causal factor from a list of four hypotheses previously developed by the authors based on their review of the domestic violence literature. Briefly, the four hypotheses are:

- Dependencies incurred in old age increase the risk of abuse or neglect.
- A child who is abused or who witnesses abuse grows up to be an abusive adult (i.e., transgenerational family pattern).
- Life crises, in either the abused or abuser, trigger abusive behavior.
- Environmental factors play a major part in bringing about neglectful or abusive behavior.

No pattern emerged that indicated one cause more important than another. Respondents did, however, raise other reasons for maltreatment, most commonly economic factors, alcohol abuse by either perpetrator or victim, and the general inability of some caretaker families to meet the needs of a dependent adult. Behavior of the victim, such as aggression, belligerence, or disorientation, were also cited as possibly provoking neglect and hostility toward dependent adults.

The authors noted as most significant the fact that so many respondents reported little or no regular, direct experience with any of the categories except passive neglect. Self-referral or referral by friends was consistently mentioned among all provider categories. Lawyers, caseworkers, adult service workers, and nurses also indicated high rates of referral from agencies.

Few professions had established reporting or intervention procedures specifically designed for domestic maltreatment of vulnerable adults. While several systems were equipped to intervene in obviously criminal behavior or on behalf of persons with no home or no personal resources, such protective services were far less common for adults in the care of relatives and friends.

In the institutional study, nursing home administrators, nurses and aides did not consider abuse or neglect to be a major problem in their homes. This conflicts with results of investigations of some of those homes by private and public agencies in Michigan.

The analysis of nursing home intake forms for 300 Medicaid patients indicated for the majority a multitude of severe physical problems requiring extensive medical and personal care. If dependency is associated with a higher probability of maltreatment, then this group is at an elevated risk. However, if this group were to become dependent on their families, a very great demand would be placed on the family members. Given existing resources and procedures, nursing home placement appears to offer the most appropriate care to meet the needs of the majority of such persons, according to the authors.

The analysis of reported crimes against the elderly in Detroit in 1978 indicated that a relatively small proportion involved family members and acquaintances. Relatives were implicated in only 1.5% of assault crimes and .2% of non-assault crimes; acquaintances account for 5.3% and 1.7% respectively.

The limitations of this study:

- The sample is not a probability sample and cannot be generalized to larger populations.
- The kinds of data collected and the methods of tabular presentation make quantification extremely difficult.
- The survey called for subjective judgements of practitioners without referral to specific case records.
- Data included opinions of those with no direct experience with maltreatment.

4. Ohio: "Abuse of the Elderly by Informal Care Providers" in Aging, September/October, 1979, by Elizabeth E. Lau and Jordan I. Kosberg.

The purpose of this study, conducted at the Chronic Illness Center in Cleveland, was to describe the types and extent of abuse of elders living in the community and dependent upon family or others for services necessary to enable the elders to remain in the community.

Lau and Kosberg classified abuse into four types:

- Physical Abuse: includes direct beatings; withholding personal care, food and medical care; lack of supervision.
- Psychological Abuse: includes verbal assaults and threats; provoking fear; isolation.
- Material Abuse: includes monetary or material theft or misuse.
- Violation of Rights: includes being either forced out of one's dwelling or forced into another setting (most often a nursing home).

A fifth category, self-abuse, is discussed in the report, but not used in the tabulations.

The methodology used in this descriptive research was a retrospective review of all case records of clients over 60 being served through the Chronic Illness Center. Workers received 404 cases, initiated in a twelve month period ending May, 1978.

Based on the study's definition of abuse, a total of 9.6% (39 individuals) of all elders seen by the agency were determined to have experienced some form of abuse during the year.

The profile of the abused elder which emerged from the 39 cases is that of a severely impaired person (over 75% had at least one major physical or mental impairment), female (77%), widowed (58%), white (75%), and living with relatives (66%).

Physical abuse occurred most frequently, existing in nearly 75% of all cases. Within this category, the most common incident was lack of personal care (49%) although direct beatings occurred in 28% of the cases.

Psychological abuse characterized 51% of the cases, with verbal assault occurring frequently (33% of all cases). Material abuse (31%) and violation of rights (18%) were less common phenomena.

In a single case, there was likely to be more than one form of abuse occurring. Researchers found a range of one to eight forms per client with most experiencing two to five forms of abuse.

The most common reactions of the abused person were denial or resignation. In only four instances did the abused person seek protection. This supports intake data which indicated that the presenting problems for referral to the Center were health problems. Abuse was uncovered only after staff investigation.

Of a total of 46 different abusers, over 90% (all but four) were relatives. Abusers were daughters twice as often as any other relative (31%), followed by sons, granddaughters, husbands and siblings (usually sisters).

In analyzing outcomes, researchers found institutionalization, occurring in 46% of the cases, to be most common. Assistance was provided in 28% of the cases, including nutrition, homemaker, recreation and guardianship services. In 26% of the cases the problem continued due to denial both by abused and abuser and the refusal to accept intervention.

The major limitation of this study is its narrow focus. It concentrated on a group of elders already identified as chronically impaired and already involved as clients of one agency in a single metropolitan area. For these reasons, its findings cannot be generalized to a larger population, nor can estimates of incidence of elder abuse be extrapolated from its findings.

Discussion of the Four Studies

What conclusions, if any, can be drawn about the nature of elder abuse from the four studies? To what extent are the studies consistent with each other? How do they add to our knowledge about the phenomena of elder abuse and what future directions do they indicate for research?

Severe physical or mental impairment as a characteristic of the abused elder is consistently and strongly supported by the three studies which developed profiles of the abused (Massachusetts, Maryland and Ohio). The Massachusetts study found that significant disability cut across all subcategories of age and appeared to be present in a much higher percentage of the abused survey population than in the elder population as a whole. Further investigation is warranted, however, to determine conclusively whether disability is independently correlated with abuse or simply a function of the sampling done (i.e., agency caseloads have a higher percentage of disabled clients).

The profile of the abused as being very old is supported by the Massachusetts and Maryland research which are the only two that investigated age. Females as the predominant class of victim was also affirmed (Massachusetts, Maryland and Ohio). Even when analyzed according to the male-female ratio in the national elder population, the Massachusetts study found a disproportionately high percentage of women as victims in each subcategory of age.

All three studies which profiled abused persons supported the contention that the abused tends to be victimized by relatives, lives with those relatives, and experiences repeated incidents of abuse.

Characterization of the abuser as a relative, living with the victim, is also confirmed as the converse of these characteristics of the abused.

No reliable estimates of incidence are available from the research because of the non-representative nature of the sample groups. Within the studies, incidence ranged from 4% to 55% of the sample population. The 4% (Maryland) estimate is most reasonable given the survey sample of community elders, but the sample size makes it suspect.

Major problems occur in attempting tc compare findings on types and frequency of abuse. These problems are due to the lack of consistency in defining types of abuse. For example, what one researcher (Maryland) includes as physical abuse (lack of personal care and supervision) another (Michigan) will label as active neglect;

and yet another (Massachusetts) will exclude altogether. Even when the definitions are somewhat comparable, as in the Maryland and Ohio definitions of physical abuse, the presentation of the data and the basic differences in the types of samples makes it inadvisable to draw conclusions with any degree of confidence. Conflicting results as to whether psychological or physical abuse is more prevalent may relate to these differing definitions and to sampling differences.

Perhaps the only general statement that can safely be made is that three of the four studies found a significant level of both physical and psychological abuse among the populations they surveyed. The exception is Michigan, where the definition was extremely narrow and where responses were not case-specific and not quantified.

The response to abuse by agencies indicates a trend toward removal or attempted removal of the abused from the home and placement in an institution (Massachusetts, Ohio). Data on resolution of the problem are unclear because they tell very little about the actual status of the abuse situation and the appropriateness or the effectiveness of the intervention. Information contained in all four studies does indicate the existence of barriers to intervention and resolution of abuse cases. These barriers consist mainly of ethical dilemmas concerning the client's right to refuse service, lack of legal authority and protection for workers, and lack of clear agency policy and procedures for handling cases of elder abuse.

The research findings clearly give strong support to the impairment/dependency theory of the etiology of elder abuse. Theories involving individual pathology, demographic and social changes, and attitudes toward elders and disabilities were not specifically addressed in any of the research designs, nor was original data presented which would confirm or refute these theories. (For a review of elder abuse causation theories, see Chapter 2.)

Research did include questions geared toward testing whether theories about family dynamics were factors in elder abuse. Specifically, the Massachusetts study attempted to elicit data about other types of abuse occurring in the family. Because the majority of respondents did not know whether other forms of violence existed, researchers felt the data did not lend itself to interpretation. The issue of whether patterns of family violence are transgenerational must await further research.

Attempts were made to investigate a number of external sources of stress to determine their correlation with elder abuse. The Massachusetts survey found in almost 75% of the cases the abuser was experiencing some form of stress--substance abuse (usually alcohol), a long-term medical problem, or financial difficulties. Alcohol abuse by either the perpetrator or the victim was also cited in the Michigan study as a reason for maltreatment.

Questions designed to ascertain income level of abusing families yielded data that must be viewed with caution. The Massachusetts survey yielded a high level of low-income families. However, there was also a very high no-response rate by professionals. It is likely that professionals do not know the total family income in many cases. It is also possible that respondents serve mainly low-income families. If that is the case, results should not be construed to mean that poor elders are more likely to be abused.

In contrast, the Maryland study states that abusing families are predominantly middle class. Since respondents were asked to judge only the economic status of the abuser, rather than supply income figures, this statement cannot be accepted with any degree of confidence.

One final comment should be made about efforts to relate factors drawn from the research on family violence to elder abuse. A recent unpublished study examined five factors drawn from the literature on family violence based on the assumption that factors involved in child and spouse abuse are similar to those in elder abuse (Wescott). Specifically, the study examined whether families who abused their elder relatives differed from those who institutionalized them (on the assumption that institutionalization is an alternative behavior pattern to abuse). The five factors were:

- Previous history of abuse in the family.
- A family member experiencing a problem with alcohol.
- The physical capabilities of the elder.
- Social isolation of the family.
- Financial resources of the family.

The study found no significant difference between families who institutionalized and those who abused. Both groups had very similar profiles on all five factors. Although these findings may indicate methodological or conceptual problems with the research rather than the factual situation, it serves to caution us about the importance of control groups. We must be certain that variables identified as prominent factors in elder abuse do not in fact exist in similar proportions in the rest of the population.

The research done in the past two years has contributed to our knowledge about elder abuse in susbtantive ways. More importantly,

it has served to raise public and professional awareness of the existence of problems of abuse and neglect. The information generated is provocative and challenges us to assess critically the strengths and weaknesses of research to date. Our goal should be to move beyond exploratory and descriptive studies by refining our research so that we can better understand the true extent, types, and etiology of elder abuse. This is essential if we are to develop strategies for intervention, treatment, and prevention.

Two major problems exist with the currently available research: lack of a common definitional framework and methodology.

As long as the definitions of the phenomena of abuse are inconsistent from study to study, comparability and collaboration will be limited. It would be most advantageous to the advancement of the state of the art if collaboration could result in the use of a common classification system. Only in this way can we be sure that several pieces of research which claim to be measuring abuse are indeed measuring the same thing. Given the fact that so little is being done to measure elder abuse, the field of adult protective services would benefit greatly from such professional collaboration.

With respect to methodology, a basic problem is the use of small and/or non-representative samples. Each of the studies reviewed cautions against generalizing beyond the particular and unique data set. This casts doubt on the validity of their own specific findings. Lack of control groups also hinders our ability to understand domestic violence against elders. By not using a control group, we cannot know to what extent the characteristics attributed to individuals in the abusive situation apply to the population in general. The findings by Wescott illustrate this point.

In discussing approaches to research on child abuse, Gelles makes a point that is equally valid to elder abuse. To paraphrase, "elder abuse" at present is a political term, not a specific behavior which can be measured and tested. Research on elder abuse in the future must examine clearly defined, discrete behaviors which are measurable.

Systematic, broad-based data collection related to elder abuse is also needed. There is currently a wealth of empirical data potentially available in states which have mandatory abuse reporting laws. Development and adoption of a carefully designed uniform data collection system would allow aggregation and comparison of this largely untapped source of information.

CHAPTER 2

THEORIES OF CAUSATION

There is very little theory in the field of elder abuse and neglect which is unique to elder abuse. Theories in this field draw heavily on family violence research. Each of the studies discussed earlier refers to the major theories which have emerged in the study of child and spouse abuse. A common and logical approach has been to test selectively those theories which seem to be most plausible as explanations of elder abuse.

The following summarizes the major theories on the causes of elderly abuse.

Impairment

Elders most likely to be abused are those with severe physical and/or mental impairments. Impairments are thought to lead to dependency which results in a high level of vulnerability to abuse. Indeed, some researchers use the generic term dependent abuse to describe conditions of domestic violence. Furthermore, dependency has long been a condition associated with child and spouse abuse. Lau and Kosberg take the view that impairments increase vulnerability to abuse as the basic assumption underlying their research. One of the four hypotheses in the Michigan research is that the normal dependencies incurred by old people increase their vulnerability to abuse or neglect by people in their domestic situation. Based on a prior literature search on family violence, researchers at Legal Research and Services for the Elderly designed their survey of elder abuse with the theory in mind that the abused elder was likely to be very old and/or dependent on the abuser for care. The presence of a severe impairment was also a basic hypothesis of the Maryland study.

A corollary to the impairment theory is the concept of learned helplessness. As dependency increases due to impairment, a person may come to feel that s/he is powerless to control life, that no efforts s/he can make will affect the outcome of a situation. This perceived lack of control, whether realistic or not, may accelerate dependency and contribute to abuse. Learned helplessness is similar to the learned role model theory formulated for spouse abuse.

Individual Pathologies of the Abuser

The basic premise of this theory is that the abuser has personality traits or character disorders which cause him/her to be abusive. Research on elder abuse has benefited from the advances in theory on other types of abuse to the extent that it is now generally recognized that individual pathology, as a sole cause of abuse, too simplistic an explanation. Nevertheless, individual predisposition to committing abuse remains one factor to be considered.

The Michigan study observes that one underlying cause of abuse is the flawed development of the abuser, although it is more useful to view it as a learning disorder rather than a disease. One of the hypotheses in this study was that maltreatment behavior, whether of a child, a spouse, or an older person, may well originate with developmental deficiencies arising earlier in life. This, combined with family structural factors, may produce abusive behavior in some people.

A second concept related to individual causality is that of the "non-normal" caregiver, a term used in the Ohio study. This would include, for example, situations in which parents have cared for a mentally ill, retarded, or alcoholic child. As the aged parents weaken and require care themselves, the adult child becomes an abusing and/or neglecting caretaker because of an inability to make appropriate judgments. This concept is also useful to describe cases where the caretaker is elderly and has experienced such organic brain deterioration that s/he is not aware either of his/her own behavior or of the effects of that behavior.

Internal Family Dynamics

A major premise in the theory of causality of domestic violence holds that violence is a normative behavior pattern learned within the context of the family. According to this theory, the child learns from observation and participation within the family that violence is an acceptable response to stress, and even learns a variety of scripts for future violent behavior. This establishes a cyclical pattern in which each generation learns violent adaptive behavior from the preceeding generation, practices it, and, in turn, passes it on to succeeding generations.

Behind Closed Doors: Violence in the American Family by Gelles, Steinmetz and Strauss (1980) appears to confirm that "violence begets violence" in the American family. This study of a representative random sample of over 2000 families indicates high correlations

between the personal observation of family violence or victimization in childhood and later experience with family violence in adulthood. Unfortunately, this study did not examine abuse of the elderly. Researchers in family studies, however, have raised the logical question of why we should assume that family violence stops at middle age. (Chapter 3 examines Behind Closed Doors in greater detail).

Failure to resolve the filial crisis is another "family dynamic" concept applicable to elder abuse. According to this theory, the healthy development requires the adult child to go beyond a state of adolescent rebellion to one of emancipation from parents. Eventually, the mature child sees the parent as an adult with an identity beyond the parental role and establishes a relationship on this basis. Failure to move beyond adolescent rebellion can mean permanent "war" on the parent and hence abuse.

The internal stress that can be placed on a family by the burden of care for an older relative is also cited as a potential cause of abuse. O'Malley describes a number of studies indicative of high levels of anxiety, headaches, insomnia, and depression among family caregivers. A New Zealand study found that on an average, chief caretakers spent 28 hours per week - the equivalent of a part-time job - providing physical and psychological assistance to frail older family members. Two-thirds of these caretakers reported negative effects on their health, including fatigue, anxiety, and general deterioration (Koopman-Boyden and Wells). Block describes that adult children, looking forward to a freer, more relaxed lifestyle after their childrearing years, may not welcome the caretaking role. Responsibility often falls on only one adult child in the family who may regard it as a burden without relief. Where children still reside in the home, a middle-aged caregiver, usually a woman, may be caught between the needs of her husband and children and the needs of her parents and/or in-laws.

When a parent moves in with adult children, it can disrupt the family routine. Power conflicts can develop between the elder and other members of the family over freedom of activity, household procedures, and discipline. All these factors can lead to unrelenting stress on someone ill-equipped to cope with it.

External Stress

Research on family violence in the 1970's increasingly recognized the importance of external stress on the family as a major factor contributing to violence. How much stress and what types of stress are

most likely to be found in abusive families is a major theme of Behind Closed Doors. The authors found that certain social factors appear to be important correlates to domestic violence - in particular, age, income, and employment status. Of lesser importence were religion, urban/rural residence, region, and race.

Demographic and Social Changes

The literature on aging repeatedly cites demographic trends which may exacerbate the potential for elder abuse. The elder population is increasing in size relative to younger age groups: the population 60 years of age or over has grown from 6.4% in 1900 to almost 15% in 1975; and the segment of the aged which is growing most rapidly is the "old old," i.e., persons over 75.

This means that today's middle-aged adult is more likely to have a living parent than counterparts in previous generations. Additionally, since family size has decreased steadily over the past hundred years, there are now fewer adult children to share the responsibilities of caring for a frail parent.

Care of the frail parent has customarily been the responsibility of married daughters or daughters-in-law who are at home caring for their children. The fact that 50% of all married women are not in the labor force by choice or by economic necessity means the pool of able and willing caretakers has shrunk at a time when the number of old people - especially the very old - has increased. These trends may well place excessive physical, emotional, and financial demands on families. These in turn may be factors associated with elder abuse.

Attitudes Toward the Elderly and Disabled

Block, in The Battered Elder Syndrome, theorizes that patterns of abuse and neglect may be reinforced by ageism. Ageism involves stereotypes that are negative in their appraisal of older people and their roles in society. Block cites a Harris Poll in which the image of older persons in America is that of "senile, lonely, used-up bodies rotting away and waiting to die." She notes that our expectations can distort our perceptions and that the resulting misperceptions may play a major role in creating situations conducive to abuse.

Since abused elders are thought to be characterized by severe disabilities, it is also useful to consider society's attitudes toward the disabled. Nearly half of the non-disabled population has primarily

negative attitudes toward the disabled, according to studies by English. Further studies indicate that the media, especially television and comic books, tend to portray evil characters as having physical disabilities or abnormalities, and that overall attitudes toward the physically and mentally ill are similar to attitudes toward the elderly. Block insists that the effect of negative attitudes toward aging be closely examined for the potential for creating abuse of older family members. For example, an adult child might justify unreasonable confinement of an aged parent on the grounds that "mother's too old and senile to know the difference."

CHAPTER 3

ELDER ABUSE AS AN ELEMENT OF FAMILY VIOLENCE: A SUMMARY OF BEHIND CLOSED DOORS

Behind Closed Doors is the first comprehensive national study of American family violence. This book is important to the understanding of elder abuse for three reasons:

- It is the first comprehensive study of family violence using a large random sample broadly representative of American families as opposed to prior studies which were done on groups already identified as abusers. This strengthens the case for applying the findings to American families as a whole.
- It tested measurement devices to score incidence and types of violent behavior and, more importantly, to predict family violence.
- It encompasses and interrelates several discrete types of domestic violence, i.e., spousal, child, sibling and parent abuse.

Behind Closed Doors does not investigate elder abuse specifically, but its conclusions can generate hypotheses concerning elder abuse.

This chapter outlines the key themes of Behind Closed Doors. For more specific information, the original work should be consulted.

Before describing the findings, theories and recommendations of the study, its limitations should be reviewed.

- The sample included intact families only, i.e., no single-parent families were included. This procedure reflects the stated intention of studying spousal violence.
- The sample excluded interactions of parents with children under three years of age.
- The response rate of 65% is lower than hoped for, although the authors feel that in light of the sensitive nature of the questions, it represents a significant accomplishment. The final size of the sample was 2,143 completed interviews. The sample population closely resembles the characteristics of the approximately 46 million American families in the United States in 1976 (with the exceptions noted above).

- The study is confined to the social causes of violence. In part, this reflects the authors' conviction that social rather than personal variables represent most causes of family violence.

- The findings may understate the extent of violence in the American family, given the first two limitations mentioned above.

The authors' definition of family violence is "any act carried out with the intention or perceived intention of causing pain or injury to another person." This definition covers everything from a slap to murder. The authors term this full range of violence "normal violence" because of the apparent frequency of all forms of violence in the family. The authors also selected the term "normal violence" and its inclusive definition to raise questions about all types of hitting within the family, including spanking. Both the term and its definition are controversial since many people regard slaps and spankings as legitimate and necessary teaching and disciplinary tools that should be free from association with the concept of violence.

Within the broad range of "normal violence," the authors identify a subcategory they call "abusive violence." This they define as "an act which has the high potential for injuring the person being hit," e.g., punching, kicking, biting, hitting with a hard object, beating up, shooting, trying to shoot, stabbing, or trying to stab.

Family violence is measured by responses to the Conflict Tactics Scale which enumerates 18 discrete behavioral responses, ranging from rational discussion to physical force, used to resolve conflict among family members. The Conflict Tactics Scale is as follows:

" a. Discussed the issue calmly.
b. Got information to back up (your/her) side of things.
c. Brought in or tried to bring in someone to help settle things.
d. Insulted or swore at the other one.
e. Sulked and/or refused to talk about it.
f. Stomped out of the room or house (or yard).
g. Cried.
h. Did or said something to spite the other one.
i. Threatened to hit or throw something at the other one.
j. Threw or smashed or hit or kicked something.
k. Threw something at the other one.
l. Pushed, grabbed, or shoved the other one.
m. Slapped the other one.

n. Kicked, bit, or hit with a fist.
o. Hit or tried to hit with something.
p. Beat up the other one.
q. Threatened with a knife or a gun.
r. Used a knife or a gun." (p. 256)

Responses to the last eight items provide the basis for statistics on the extent of general family violence. This includes the entire range of physical behavior from pushing and shoving to the most severe, such as shooting or stabbing.

Additionally, statistics were analyzed for severe violence only, i.e., those actions enumerated under the definition "abusive violence" (the last five items on the Conflict Tactics Scale). It is these more severe forms that are described under the general labels of wife-beating, husband-beating, and child abuse.

Findings

Spousal Violence

In a one-year period, 16% of husbands and wives commit at least one violent act against each other. During the entire length of the marriage, 28% engage in at least one act of violence. This represents the percentage of persons admitting to such assaults.

The incidence of wife-beating, i.e., actions confined to the more severe forms of violence, was 3.8% for the year immediately preceding the study (one out of every 26 wives). Extrapolated to the population of American families, this means 1.8 million wives each year are beaten by their husbands.

The incidence of husband-beating is even higher, at 4.6% (one out of every 22 husbands per year). It is not clear, however, how much husband-beating is part of mutual violence or involves self-defense. Other studies indicate that husbands engage in more violent actions and do more physical damage.

Almost one out of every eight couples admitted to engaging in spouse abuse at some point in the marriage. Spouse abuse is a pattern for about half of the couples involved in it over a one-year period; for these couples, abuse is not an isolated event occurring only once or twice.

Responses to questions on the prevailing norms or attitudes about marital violence tend to confirm that for many a marriage license is a hitting license. A full 25% of the wives and 33% of the husbands felt that slapping is necessary, good, or normal.

Violence Toward Children

Interviewers randomly selected one child per family for study. Of parents with children between the ages of 3 and 17, 73% reported using violence at some time during the child's life. Use of milder forms was most common: 41% pushed or shoved the child in the study year, and 46% sometime during the life of the child. Spanking or slapping of the child was reported by 58% of the respondents for the year and 71% at some time during the child's life.

Extrapolating the findings of more severe forms of violence, the authors estimate that between 3.1 and 4 million children between the ages of 3 and 17 living with both parents in 1975 had been kicked, bitten, or punched by a parent at some time in their lives. Between 1 and 1.9 million experienced these actions in 1975. Between 1.4 and 2.3 million children are beaten at some point while growing up, and between 275,000 and 750,000 were beaten in 1975. Between 900,000 and 1.8 million have had a parent use a knife or gun on them in some fashion.

As with spousal abuse, there is a pattern of violence, with spankings/slappings occurring 9.6 times per year; kicking/punching/biting, 8.9 times; and beatings about 6 times.

Mothers are more likely than fathers to use violence, including "abusive violence," on their children. Possible explanations include: mothers spend more time with their children; they are held more responsible for the children's development; and children interfere with their plans and self-concepts more than the fathers.

Sons are more frequently the victims of violence than daughters. Younger children (aged 3-4) appear more vulnerable, suffering violence during childhood 86% of the time. This figure drops steadily to about 33.5% for teenagers aged 15-17. It should be recalled that children under three were excluded from the sample although other studies indicate they are the most vulnerable to abuse of all age groups.

Again, prevailing cultural norms support parents in their use of violence against their children for discipline and socialization. When asked whether slapping and spanking of a twelve-year-old child was necessary, normal, or good, 70% said it was normal and 71% said it was good.

Sibling Violence

Sibling violence is virtually universal. In 82% of the families, some violent act had occurred within the year; 53% of it was severe,

i.e., kicking, biting, punching, or hitting with an object. Indications are that parents often view fights between their children as practice for skills that are required to deal with friends and schoolmates. Girls are only slightly less violent than boys.

Causes of Abuse

The theories of causation of family violence described in Behind Closed Doors can be summarized as follows:

- The norms of American Society as a whole support and legitimize the use of violence in the family to solve disputes, to train, to punish, and to control.
- Violent behavior is learned within the family context and becomes transgenerational. A significant percentage of persons who grew up in homes characterized by spousal or child violence in turn practices these forms of violence in their adult lives and passes them on to their own children.
- Social factors such as income, age, employment status, and education are related to domestic violence.
- Stress is a major contributor to family violence.

The authors cite answers to attitudinal questions in their own study as well as results of other attitudinal polls to support the first and underlying cause. They also point to the media - to television shows in particular-as presenting violence or threats of violence in situations intended to be comical or heroic.

To substantiate the second theory, the authors present statistics from their own study which indicate, among other things, that men who have seen their parents attack each other are three times as likely to hit their own wives. Roughly the same statistic held for women. People whose parents were never violent had the lowest rate of husband-and wife-beating (2%). The one-third of the respondents with teenagers who reported hitting their teenagers during the year had an almost identical rate of being hit by their own parents when they were teenagers (37.3%). Those who experienced the most punishment as teens have a rate of spouse beating four times greater than those whose parents did not hit them.

In addition to their own research, the authors cite other studies which indicate that murderers, presidential assassins or would-be assassins, violent prison inmates, and violent juvenile delinquents seem to have experienced frequent and severe violence as children.

Specific social factors were examined by taking the findings on violent families and analyzing them according to the following variables: region, city/county, race, religion, age, education, income, occupation, and unemployment. The analysis indicates that some of these factors do have strong bearing on inclination toward family violence. Most strongly related are:

- Age. Younger families, those where the respondent was under 30 years of age, were more active statistically in every form of domestic violence.

- Income. The lowest income families had the highest rates of family violence. This relationship is the strongest for spousal violence.

- Employment Status. Families where the father was unemployed or employed only part-time had high rates of violence.

To a lesser extent, religion, urban/rural residence, region of the country, and race were related to violence in the home.

Under factors of stress, the following characteristics were analyzed: number of children in the family, a "stress score" (based on responses to a list of eighteen common stressful situations such as the death of a family member or loss of a job), the authoritarian exercise of power, and degree of shared decision-making in the home.

For those scoring above average in the stress test, the higher the score, the greater the association with child abuse. The correlation with spouse abuse was even higher.

The safest homes were found to be those with fewer than two children where the husband and wife experience little stress and where a democratic system is used to make decisions.

The authors point out that the standard treatment for violent families usually consists of personal counseling for the violent family member(s). This form of treatment is based on the assumption that something is "wrong" with such a person. Although the authors indicate that personality factors cannot be ruled out as a cause of family violence,

they conclude that personal counseling will be inadequate to end or prevent violence that has as its primary causes social factors. In short, psychological help cannot effectively treat or prevent family violence caused by poverty, poor health care, or social norms that legitimize physical force.

Prediction of Abuse

In order to see if all the separate characteristics associated with spouse abuse make up a constellation which can be used to predict spouse abuse, the authors developed a list of the twenty-five most common characteristics called the Spouse Abuse Prediction Checklist. One point was assigned to each characteristic. An individual family's score could range from 0 to 25, depending on how many of the characteristics it exhibited. The Spouse Abuse Prediction Checklist reads:

" Important for both wife-beating and husband-beating:

- Husband employed part-time or unemployed
- Family income under $6,000
- Husband a manual worker
- Husband very worried about economic security
- Wife very dissatisfied with standard of living
- Two or more children
- Disagreement over children
- Grew up in family in which father hit mother
- Married less than ten years
- Age thirty or under
- Non-white racial group
- Above average score on Marital Conflict Index
- Very high score on Stress Index
- Wife dominant in family decisions
- Husband very verbally aggressive to wife
- Wife very verbally aggressive to husband
- Gets drunk but is not alcoholic
- Lived in neighborhood less than two years
- No participation in organized religion

Characteristics that are important for wife-beating

- Husband dominant in family decisions
- Wife is full-time housewife
- Wife very worried about economic security

Characteristics that are important for husband-beating

- Wife was physically punished at age thirteen plus by father
- Wife grew up in family in which mother hit father
- Wife is a manual worker" (p. 203)

Results indicate that the checklist is a useful predictive tool. Couples with only three of the characteristics have violence rates under 2%. The rates then increase sharply. Of couples with twelve or more characteristics, about two-thirds are violent. This tally referred to the total range of normal violence. A higher checklist score produced comparable results with regard to abusive violence.

The authors also developed a Child Abuse Prevention Checklist. The checklist predicted child abusers only about one-third of the time. This means it was wrong about two thirds of the time. The authors caution against the use of the checklists, particularly the Child Abuse Checklist, for predictive purposes. Checklists raise serious ethical and legal issues about the possibility of intrusive family surveillance and false labeling.

Reducing Family Violence

The authors describe several short-term solutions to protect victims and/or reduce stress:

- The child welfare services must have adequate numbers of well-trained staff with the capacity for immediate intervention and for providing services which reduce stress, educate families in parenting, and offer continuity of care.
- More emergency shelters and day care programs should be established.
- Police should be given better training in handling domestic disturbances.
- Courts need to streamline mechanisms for handling domestic violence cases.
- Both police and courts must eliminate sexist attitudes and hands-off policies in dealing with abuse cases.
- More family planning and individual and marital counseling should be provided.

The long-range solutions presented in Behind Closed Doors require reconsideration and alteration of some of our society's fundamental attitudes, values, and behaviors. They are:

Step 1 Eliminate the norms which legitimize and glorify violence in society and in the family. This includes corporal punishment in any form.

Step 2 Reduce violence-provoking stress created by society. This includes unemployment, poverty, and poor health care.

Step 3 Integrate families into a network of kin and community. Since social isolation is so frequently characteristic of child abuse, membership in groups is needed to reduce isolation and alienation.

Step 4 Change the sexist character of society and the family. Sexual inequality in the home and in society is at the heart of the battle of the sexes. It is a prime contributor to violence among family members.

Step 5 Break the cycle of violence in the family. Reduce and gradually eliminate the use of physical punishment and develop alternative technologies for child rearing and education for parenthood programs.

By the authors' own admission, these long-range solutions are monumental. They challenge our basic notions about the privacy of the family and are seemingly unworkable. The authors contend however, that the alternative is the continuation and perhaps the escalation of a deadly tradition of domestic violence.

PART II: HANDLING CASES OF ELDER ABUSE: FACETS OF INTERVENTION

General Principles

Efforts to assist in cases of elder abuse and neglect should be governed by the following six principles:

1. The Client's right to self determination.

Competent adults are entitled to decide where and how they live and whether or not they receive social services and other forms of assistance. This concept embodies a number of basic civil rights.

2. The use of the least restrictive alternative in treatment and placement.

This principle has emerged as a legal doctrine from the mental health area. It embodies the concept that society should intervene to assist people only to the minimum extent necessary; that an individual should retain maximum independent decision-making.

3. Maintenance of the family unit wherever possible.

The evidence available strongly suggests that most victims of abuse and neglect will receive better care if the abuse or neglect is dealt with as a family problem and if the family is given the necessary resources and assistance to overcome the problem.

4. The use of community-based services rather than institutionalization wherever possible.

Institutions such as nursing homes are no substitute for family life. They deprive older people of freedom and familar surroundings. In most instances the older person is much happier if kept in the home and supported with services from the outside.

5. The avoidance of blame.

To place blame is generally dysfunctional. It may antagonize the abuser, making that person more difficult to deal with, and reduce the chances for terminating the abuse or neglect.

6. Inadequate or inappropriate intervention may be worse than none at all.

Intervention and assistance that promise a great deal and deliver little, or come at the abuser and victim from all sides, may cause them to reject assistance now and in the future. In some instances, such unbalanced intervention may greatly increase the risk to the vicitm.

CHAPTER 4

IDENTIFICATION, ASSESSMENT, AND MANAGEMENT

Barriers to Access

The Massachusetts report found that 70% of all the professionals responding to the survey indicated that some barrier to service provision existed. Of those respondents who reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "fear of retaliation" from the abuser, feelings of kinship and love for the abuser, or simply as a refusal to accept services.

Fourteen percent of the surveys indicated that a legal problem constituted the barrier to care. Legal problems included:

- Lack of legal protection for workers who intervene in the family situation.
- Lack of eye witnesses to the abusive act (lack of proof) when the abused person refuses to file a complaint.
- Lack of an appropriate person to accept guardianship for the elder.
- Requirement of a formal complaint from the abused individual before police can act.
- Unwillingness of witnesses to testify.
- Lack of statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and/or family with whom the elder was residing was the principal barrier to services provision. An additional 11% stated that lack of services was the barrier. Needed services which were unavailable included protective services for adults, respite care facilities, temporary shelters able to care for persons requiring assistance in activities of daily living, emergency foster care for elders, and nursing home placements. Lack of coordination among service providers was also cited in this category.

In 9% of the surveys, access to the elder was cited as the barrier to services provision, i.e., the worker was barred from entering the home by the abuser or family. An additional 3% of the surveys stated that agency attitudes were a barrier to service. Examples include: a worker deciding that the abuser was "not reachable by counseling"; an agency dropping the client because of an obstructive family; a doctor refusing to acknowledge the problem and take some form of action; and time demands of the case forcing a worker to reconsider his/her involvement with the case.

Perhaps the most difficult and dramatic barrier to access occurs when the worker finds that a relative discourages or even prohibits a meeting with the alleged victim. The worker may be forbidden to enter the house, the victim reported as too ill to see anyone, telephone calls intercepted by family members, or legal and physical threats directed at the worker.

Some workers, frustrated by such barriers, have resorted to using housing inspectors or landlords to investigate for them. Such approaches are usually illegal. Some workers call in the police to investigate. This approach has the unfortunate effect of criminalizing what is fundamentally a disturbed family relationship and of polarizing the relationship between the worker and the family. The presence of the police often precludes further serious efforts at improving conditions in the home. Institutional placement is then the only alternative remaining. In general, the police should be used only when the victim is believed to be in serious and imminent danger.

Better approaches to family and victim resistance to assistance include:

- Offering services that can help both abuser and victim.
- Checking eligibility for social, health, and income programs.
- Avoiding reference to "neglect" or "abuse."
- Sympathizing with family members who bear the burden of caring for the victim.
- Focusing on the future by pointing out that conditions can be made better for the family.
- Coming back when the resistant family member is out.
- Approaching other family members.
- Being patient.
- Offering alternatives to abusive interaction.
- Remaining friendly and concerned with both abusing/neglecting person and the victim.
- Coming back a second and third time if necessary.

In the process of seeking access to a client/victim, the worker must evaluate his or her own personal safety, particularly in cases of violent abuse and where drugs or alcohol are involved. If the worker is apprehensive, he or she should consider taking a second worker or visiting the home with a neighbor. If all else fails, it may be necessary to call the police or, where the victim is incompetent, have a legal guardian appointed who can provide access or remove the victim from the home.*

Signs of Abuse and Neglect

Absent confirmation by the client, the worker must make an initial determination based on all the available evidence. The following are signs that should be regarded as suspicious or at least grounds for further investigation of physical abuse or neglect:

- bruises
- welts
- lacerations
- punctures
- fractures
- evidence of excess drugging
- burns
- physical constraints (tying to beds, etc.)
- malnutrition and/or dehydration
- lack of personal care
- inadequate heating
- lack of food and water
- unclean clothes and bedding
- lack of needed medication
- lack of eyeglasses, hearing aids, or false teeth

None of these conditions automatically indicates abuse or neglect. Older people, especially those with impairments or under medication, may fall down or otherwise accidentally injure themselves. Any caretaker may fail to provide needed services on any given day. In general, a cluster of these conditions or the recurrence of one or more raises the probability and should result in further investigation.

Other forms of abuse and neglect (those that are not physical) are much more prevalent and also more difficult to identify. Psychological abuse is a particularly difficult area. There is no general consensus on what fits into this category, and there may never be. Shouting, the display of strong emotions and the use of harsh language may be a

*See Chapter 5 of this manual for information on legal issues and remedies for further discussion of intervention problems and theories.

social or cultural norm in a particular ethnic group. Words and emotions that may be harmful in one family are not necessarily so in another family. In this area the worker must take great care not to project his/her own attitudes and values. With this warning in mind, the worker should know that the following may signify the presence of psychological abuse:

- threats
- insults
- harassment
- withholding security and affection
- harsh orders
- refusal to allow travel, visits by friends, attendance at church

Before arriving at any conclusions based on the presence of these "psychological" actions, the worker should attempt to evaluate their impact on the older person. The following responses may indicate psychological abuse:

- resignation
- fear
- depression
- mental confusion
- anger
- ambivalence
- insomnia

Any of these attitudes or mental conditions may result from a wide range of factors and may not be primarily caused by hostility or indifference by the caretaker or other member of the family. Remember, the victim, unless s/he is mentally disturbed, is ultimately the best source of information on whether or not there is abuse or neglect.

It should be noted that physical neglect or abuse is frequently accompanied by some form of psychological abuse and attendant psychological problems.

Financial abuse, or the misuse of the victim's income and expenses, is often extremely difficult to determine. Many people are by nature private about their financial affairs, and outside evidence is difficult to obtain. Again the victim is the best source of information about this subject, although in most cases of suspected financial abuse, the potential victim has turned management of his or her financial affairs over to another person. As a result, there may be some confusion about finances.

If financial abuse is suspected, the worker should seek information about income that covers:

- interest on bank accounts
- stock dividends
- social security
- supplemental security income
- veterans benefits
- pensions
- disability benefits

With regard to resources, the worker should inquire about:

- savings
- real estate
- stocks
- jewelry
- life insurance

The worker should attempt to determine if there is a power of attorney (written or oral) that gives someone authority to act in financial matters on the client's behalf. The worker should also ask whether or not a conservator has been appointed by a court to manage the finances of the client. The conservator will often be a member of the family in a position to misuse the client's property. However, if there is a court ordered conservator, reporting to the court (usually probate court) is required regarding expenditures. In many cases the whole situation will be extremely informal with a family member handling the financial affairs without making regular or clear reports to the client.

A second stage of inquiry concerning financial abuse should involve estimating whether the conditions surrounding the older person reflect the available finances. Check housing, level of personal care, nutrition, medical care, clothes, transportation, and social opportunities.

Are these adequate? Do they satisfy the older person? If there appears to be a discrepancy between the assets and the adequacy of these items or the satisfaction of the older person, there may well be financial abuse. Overdue client bills may also indicate financial abuse. In a number of reported cases, a family member or caretaker has misused client funds that should have been used to pay client rent and utility bills.

In addition to the specific signs and factors discussed above, the worker should be aware of the general profiles of both the abused and/or

neglected victim and of the abusing or neglecting family member that have emerged from the available data. These two profiles may help to put isolated bits of evidence into context and increase the probability that the worker can determine whether or not abuse or neglect exists.

General Characteristics of Abused and Neglected Persons*

The four major studies undertaken in the field of elder abuse point out the tentativeness of their findings. In general, these studies are not adequate to provide a comprehensive set of characteristics of the abuser and his/her victim.

Yet, the completed studies provide an approach to the problem, and a victim profile does emerge. The Massachusetts study, The Battered Elder Syndrome, and the Lau and Kosberg studies all point out that the victim tends to be an "older" elderly person; with 55% of the citings in the Massachusetts survey found in persons above the age of 75. All three studies agree that abuse is observed to an overwhelming degree in elderly women (77% in Lau and Kosberg, 80% in Massachusetts and 81% in The Battered Elder Syndrome).

The victims of abuse usually live in a family environment with an adult child or other family member who abuses them.

The overwhelming majority of abuse victims suffer from one or more disabilities which place them in a vulnerable and service-demanding position. 75% of the Massachusetts survey respondents stated that the abused person had a mental or physical disability which prevented him or her from meeting basic daily needs. Block found that 62% suffered some form of mental impairment. Lau and Kosberg report that 41% suffered either partial or total mental confusion.

Although more research needs to be done, it is easy to imagine that a victim of abuse is usually a person in some discomfort who may need constant attention and in-depth care. In some cases the older person may act cantankercusly, demand care, and use guilt as a motivating force.

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* For a complete analysis of the literature in the field of elder abuse, see Part I.

The older person may need a special diet, special hygiene care and shows of affection and caring. In some cases there may be a history of family violence, alcoholism, drug abuse or other stress that may prevent the neglecter/abuser from caring for the elderly person. The vulnerable elder may have been an abusive parent.

In order to understand the psychodynamics at work in an abusive situation it may be helpful to put yourself in the role of a dependent and ailing older adult. The following exercise should assist you in understanding the victim's point of view.

Imagine yourself as an older person who is now incapable of caring for your own basic needs. You move into your child's home and away from the home you have known for many years.

Moving has brought up old memories of the family - memories with which you may not be entirely comfortable. Your relations with your children were never ideal and you may feel it's too late to establish good ties.

Now you are a burden on your children - people you never really knew as they were growing up. You may have even abused them at one time in a period of great stress.

Your promise of golden retirement is shattered by inflation, a small fixed income and, perhaps, the loss of a spouse. You may feel yourself deteriorating physically and mentally and there are times when pains assault you. Now you are forced to compete with your grandchildren for attention, affection and care.

You may feel trapped in this home in which your personal cleanliness, privacy, nutrition and medical needs are low on the list of family priorities. Passivity, boredom, resignation to filth and withdrawal become your means of escaping. At this point it seems hopeless to reach out for aid.

Characteristics of the Abuser

The Massachusetts Survey found that in 75% of the abuse citings, the abuser lived with the victim, with 86% of the abusers being relatives of the victim. The Battered Elder Syndrome found close correlation, with 81% of abusers being relatives of the victim. They also found that females (58%) more often than males are the abusers while the Massachusetts Survey found that sons (24%), husbands (20%), and daughters (15%) made up the largest

categories of abusing relatives. Lau and Kosberg came up with results citing 30% of abusers as daughters, 14% as sons, 14% as grandaughters, 12% as husbsnd/spouse and 12% as siblings (usually a sister) as victimizer.

According to the Massachusetts Survey, the abuser was usually experiencing some form of stress when the abuse occurred. 28% suffered from alcoholism or drug addiction while 18% complained of a long-term medical complaint, long-term financial stress (16%) and lack of needed services (9%). The Battered Elder Syndrome points to psychological (58%) and economic (31%) factors leading to abuse. 63% of the respondents to the Massachusetts survey indicated that the vulnerable elder requiring a high level of emotional and financial support was a source of stress. Abusers tend to repeat their abuse according to The Battered Elder Syndrome in 58% of the cases studies.

One of the most interesting statistics to come out of the studies undertaken relates to the attempt to get some form of help. The Battered Elder Syndrome indicates that in 95% of the cases studied an attempt by abuser or victim was made to obtain some sort of service. Social service agencies were most often contacted. This fact may point to the poor communication skills of the abuser and/or the victim. After a failed attempt at reaching other family members or a service provider, the abuser or victim may give up further attempts.

Two scenarios describing abusive situations follow. They are offered in order to help workers understand the dynamics which may lead to instances of psychological and physical abuse and neglect.

Scenario 1: Imagine you are a middle-aged woman who has built up her meager reserves of self confidence to find a job. The kids are grown and gone, leaving an emptiness in your life. You look forward to office work and the friendship and communication associated with the non-home environment.

After your mother has an operation, it becomes apparent that she can no longer care for herself. She comes to stay with you and all plans for work are scrapped. Your self-confidence slowly ebbs. You reach out to the community for in-home services. You find they are only for low-income persons. Your mother is ineligible because she is living in your home.

You feel betrayed, seeing your work plans crumble. You begin to spend more time away from home in order to avoid your mother. You know she needs many types of care, but you cannot face life as a caretaker. At times you let her go for days without a bath. You serve her poorly prepared meals and abruptly leave the room without offering conversation. You know this is cruel punishment for your mother but you can't help yourself.

Scenario 2: Suppose you are a middle-aged bachelor son. Mother, an 84-year-old woman in failing health, comes to stay. She has a small pension which provides for in-home care services such as washing, feeding, etc.

After losing your job, you resolve to live on the pension with Mom. All outside services are dropped as you feel you can care adequately for her. At the same time, you blame her for your failure to marry and to make a separate life for yourself. Now her presence disrupts your social life. Her attempts to communicate her needs to you seem like whining, and you criticize your mother for her ungratefulness.

Abuse somehow occurs. First as a slap on the cheek when Mom won't eat fast enough. You continue the slapping at mealtimes, saying to yourself that Mother needs discipline for her childishness. As the abuse continues, you build up a justification for continuing the abuse.

Asking a social service agency for help is unthinkable. It would be embarrassing and humiliating to have a social worker type of person in your home.

You are also frightened by legal intervention which might cause your mother to be moved, along with her pension. You might even go to jail.

How Cases Come to Light

There is evidence that victims and perpetrators of abuse rarely seek outside help or support specifically for abuse. In fact, the Massachusetts study found that in at least 70% of the abuse cases cited, the active involvement of a third person (someone other than the victim and his/her family) was required before the case was brought to the attention of concerned professionals and paraprofessionals. This suggests the need for some form of outside, third-party observation as a means of identifying abuse cases.

On the other hand, as pointed out earlier, The Battered and Elder Syndrome indicated that in 95% of the cases studies, either the victim or abuser requested assistance from an agency. Often the assistance was not provided. This finding suggests that most professionals and paraprofessionals are not attuned to the possibility of elder abuse, regard intra-family violence as a private family matter, or believe (rightly or wrongly) that reporting the problem is a breach of professional confidentiality. A great deal more education and training is needed to prepare workers to recognize and respond to what are apparently indirect cries for help.

Case of abuse come to light in various ways. An alert neighbor or friend may call adult protective services or the police. Visiting nurses, homecare providers, court investigators and others who go directly into the home to care for or monitor the elderly client are in the best position to identify possible forms of abuse and neglect.

A few states have established elder abuse mandatory reporting laws (MRL) which provide for immediate investigation upon receipt of an abuse report. In effect, these laws charge professionals who come into contact with older persons to become more aware of possible abuse and to guarantee that reported cases are dealt with in a responsible way by an established authority.

Who Generally Reports Abuse?

Frequently, professionals are called into situations of alleged or real abuse. Health care professionals provide the most expertise in evaluating physical signs of abuse and neglect. Often the only time to detect abuse will be during a visit to the victim's home.

The studies on elderly abuse point out that visiting nurses, home services staff, medical social workers, probation officers, hospital social services directors, and home/health aide staff report relatively high rates of elderly abuse.

The Massachusetts Study indicates that emergency room supervisors, police, and regional welfare protective services managers produce the lowest rates of citings. All three groups, especially emergency room supervisors, are presumably in a position to identify more cases.

Interviewing the Victim

The victim may range from someone only too willing to discuss the abuse and seek and end to it to someone who denies anything is wrong. In addition to outright denial, problems the worker may encounter from the victim during an initial or subsequent interview include:

- uncertainty over the worker's role, purpose, or attitude
- unwillingness to authorize affirmative steps
- reluctance to be specific
- indecision
- ambivalence about the problem and/or the abuser
- fear of retaliation
- double messages or frequent changes in basic decisions
- confusion (from fear, drugs, psychological withdrawal, etc.)
- irritability
- non-responsiveness to answers

The worker should try to locate the source of the problem. Is a family member listening in? Has the worker adequately explained his or her purpose? Is the client in pain, under sedation, embarrassed about lack of cleanliness? Can the problem be solved or minimized?

In evaluating the victim's circumstances, the worker should be aware that sustained abuse, significant physical disability, or repeated failures to succeed in obtaining help can lead to learned helplessness. The victim may have been conditioned into believing that s/he is more helpless or vulnerable than in fact is the case. The worker may have to provide a great deal of support and encouragement to counter this problem. The worker should also be aware of the role his/her own emotions and attitudes may play in the interview and throughout the case-handling process. The worker should avoid casting blame or making harsh moral judgments. Even if these are not articulated, they may be communicated non-verbally.

The worker should also avoid the rescue syndrome. Most solutions to abuse or neglect will only be partially adequate and will take take time to achieve. The dependency needs of a victim and/or family cannot all be met by the worker. The worker must have the patience and strength to deal thoughtfully and carefully with what may be a repulsive, depressing, or frightening situation. The worker should attempt some sort of realistic self evaluation before handling such cases. Not everyone is equipped to manage a case with the necessary detachment, and most cannot handle many cases over a sustained period of time.

The following are some general guidelines on interviewing techniques that have been found successful in abuse and neglect cases.

General Interviewing Techniques

Most of what a worker learns about client problems comes through interviews with that client, or with others who may have significant information. Interviewing them is one of the most important skills for any helping professional. One social work theorist noted that it is as important for a caseworker to practice interviewing as it is for a musician to practice scales. Learning to interview means quite literally learning communication, not just verbal interactions. The interviewer must try to remain aware not only of the work content of a client's comments but the accompanying emotional and physical content as well. Eye contact, body language and vocal pitch all play a role in developing the interview as a data gathering/data synthesizing situation. While excellence only comes with experience, there are some points which may be helpful.

PRIVACY: Every client has a right to privacy in the interview. This may be especially true for victimized elders since there is a tendency to infantilize dependent people who are under stress. Try to avoid interviews with audiences, even trusted friends or homemakers. There are obviously exceptions, but these should occur at the client's urging and they should be accompanied by some discussion about what it means to "open" an interview to others. Every client wants to believe that s/he is being taken seriously and privacy is a hallmark of "seriousness" in our society. If you can offer your client nothing else, you can at least offer total privacy and strict confidentiality.

PACING: Athletes pace themselves for the total probable length of an event; interviewers should do likewise. Once you've determined approximately how long an interview should take, try to develop a schedule that not only accomplishes your goal, but which recognizes your client's needs as well. In cases of chronic abuse or neglect it is essential that the client feel that s/he has the right to react, ventilate etc. For example, if you must tell a client that his/her daughter has threatened you and has refused you access on two occasions, do so in the first or second third of the interview. The remaining time should be allotted to the client's needs and feelings, even if they are likely to be highly emotional.

PLANNING: Just as the worker develops an overall caseplan, s/he should give some thought to the individual interview plan. What is it that you want to accomplish with your client? How should the interview proceed in order to achieve this goal? Is this a goal which your client shares and understands? What if your client has his/her own agenda? It pays to be flexible, but not so flexible that interviews are haphazard and aimless.

PITCH: Virtually everyone responds to the pitch and tone of another person's voice. People react to this, sometimes without knowing it. Clients under the stress of an abusive or exploitive situation may be sufficiently regressed that how you say things is as important as what you say. Try to keep your voice well modulated and low. Try not to sound excited or shocked. Your feelings should not get in the way of your client's time for free expression.

PUNCTUALITY: Many clients already have negative feelings about interaction with social service staff. There is no need to risk engendering or increasing resentment because of delay. Always be on time for appointments. Keep to agreed upon schedules for service delivery.

Some Specific Interview Techniques

QUESTIONING: In order to get answers, questions must be asked; however, interview questions can be framed in at least two very different ways. For example, family information can be elicited in each of the following:

Directly: How many brothers and sisters do you have?

Non-Directly: Could you tell me something about your family?

The direct question, it's true, will elicit the simple piece of data you want. The non-directive question, though, will not only give you the "facts", it may well give you some "feelings" as well. The non-directive question can be especially useful with clients who are reticent about talking.

Many workers routinely open all interviews with a non-directive question of limited relevance such as, "How have things been going since the last time we got together?" Presumably the worker already has some agenda for the interview and a non-directive opening may allow the client to raise his/her concerns. The best approach is one which balances directive and non-directive questions.

Another method of questioning a client is the "one word lead". If a client makes a statement that is unclear, unfinished or ambiguous, this technique may be useful. For example, if your client says, "Yes, all the children turned out fine except for Dottie...," you might simply respond, "Dottie?" Such a response asks for more information about the relationship without offering any particular boundaries. This technique can be very useful with older persons who are able to reminisce. Even with clients who tend to wander, the one word lead can be a tool to help focus.

SILENCE: Whether it's golden or not, silence can work to the interviewer's advantage. Most people are made sufficiently uneasy by silence that they will plunge ahead verbally to bridge the pause. If the interview has begun at all and seems to be moving in the desired direction, then silence from the interviewer can be quite valuable. As a general rule, no silence should run beyond five minutes. If the silence seems destined to continue, the worker might say, "Perhaps this isn't a good time to talk . . . would you like to set up another appointment?" Leave the decision to terminate a silence in your client's hands.

Finishing a client's sentence is one of the most common worker responses to short silences after an incomplete statement. Regardless of how difficult it is to avoid doing so, do not complete your client's sentence. Even if the client has a serious speech or motor-neural disability, s/he deserves the time it will take to listen and to listen carefully. If the incomplete statement is that important, consider a one-word lead or simply ask your client to complete the comment.

EMOTION MODELING: For those clients who are especially passive or who seem ambivalent about emoting, "modeling" may be both a useful short-term technique as well as a productive long-term strategy. Emotion modeling allows the worker to suggest an appropriate emotional response to his/her client. For example, if a client says with little or no apparent emotion, "My husband left me. . . with three kids and it was the middle of the Depression. . .", the worker might reply, "That must have made you very angry." In general, choose emotions which are active and assertive, particularly for those clients who may need support in expressing something other than a passive response. Emotion modeling can be valuable, too, in situations where the client admits abuse or exploitation but is ambivalent about taking action. For example, the worker might employ this gambit, "Look, Mrs. Emerson, you've been a fighter all your life, this is certainly no time to give up." Emotion modeling must be used in

the context of an on-going relationship, otherwise it can degenerate into a pep-talk attitude of questionable professionalism.

There are some cautions about modeling. Clients who are psychiatrically disabled and experiencing "flattened affect" (e.g., schizophrenics and depressives) probably won't respond. Similarly, organic brain damage clients will require other, longer term methods. If you have questions, seek a consultation. Try to find a mental health professional with geriatric/diagnostic skills. A good differential diagnosis can save you lots of time and energy.

(The following list of rights and principles is excerpted from Contemporary Social Work, Donald Brieland, et al, authors.)

CLIENT'S NEEDS AND RIGHTS	PRINCIPLES FOR THE WORKER
1) To be treated as an individual	Individualization
2) To express feelings	Purposeful expression of feelings
3) To get sympathetic response to problems	Controlled emotional environment
4) To be recognized as a person	Acceptance
5) Not to be judged	Non-judgmental attitude
6) To make personal choices and decisions	Client self-determination
7) To keep secrets about her/himself	Confidentiality

CLOSING THE INTERVIEW: Always close your interview with a clear and explicit indication of what happens next. Another appointment? More information? Particularly in abuse cases, your client may be so anxiety-ridden that short-term memory has begun to fail. Remember that you are more familiar with agency routine than s/he is. Relief and resettlement workers in disasters must listen to essentially the same story over and over again. Despite that, though, it's a new story and a new routine for each of the clients. Part of a well-planned interview will be a thoughtful and orderly termination.*

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*Some of the material in this section was drawn from Contemporary Social Work, cf. supra and from A Primer of Social Casework, Elizabeth Nicholds.

Case Assessment Procedures

Following the initial investigation, it is necessary to make an assessment of whether or not abuse or neglect exists in the case.

Suggestions for Assessment Techniques

Assessment, not unlike interviewing, depends upon striking a balance between directive and non-directive approaches. Some of the most valuable material may be elicited simply by looking and listening. For example, some issues about gait, dress and hearing acuity can be resolved simply by observing the client in the home. Similarly, cigarette burns in clothing or furniture may be indications of potentially hazardous behaviors. Sometimes merely watching a client try to locate a Medicare card will give useful insight into problem-solving ability.

Assessment Cautions

Certainly all social service interactions should be free of personal judgments; however, protective services assessments in the area of abuse and neglect in particular should be non-judgmental and problem-focused. Remember, the first concern of protective services is whether harm is imminent or occurring. It may be useful to know that a client sleeps on a mattress without bedding or lives in a house which has unmistakable odors; however, the major question is whether or not those things are likely to harm the client.

Intervention strategies are hard enough to implement; use them only when necessary. If uncertainty exists, maintain confidentiality but consult another worker. This is especially true when actively considering more restrictive alternatives such as guardianship or civil commitment. Assessment teams are most useful with these "restrictive" cases because the team approach adds other perceptions to the evaluation process. If formal team structure exceeds the resources of an area, consider assembling an informal "consultation" team by telephone. This approach was adopted by one social worker involved in a dozen guardianship cases because she wanted outside opinions about her assessments.

Finally, assessing a client, particularly a potentially abused or neglected client, requires patience and practice. The assessment is only as good as the person using it. Whatever evaluation form is used, be familiar with it. Practice assessing client capabilities

with co-workers. Rely on descriptions of behavior ("client raises herself from chair using right arm for support") rather than comments ("client is paranoid"), unless you give specific description supporting the diagnostic term ("client says family hates her...sister has phone tapped..."). In general, be wary of any label - psychiatric or otherwise. Never trust your memory. Write your assessment notes as soon after the interview as possible. If the evaluation seems uneven or leaves areas untouched, make a list of points requiring clarification. Develop a strategy for eliciting that information and return to the client for another appointment.

Because of their compelling situations, potentially abused or neglected clients sometimes will not give a worker or an agency a "second chance". If the client does not feel that the case plan really addresses his or her needs, the client may well discharge the worker. A good assessment can begin establishing the kind of relationship which will diminish the likelihood of such occurrances. The assessment instrument at the end of this chapter is used by the State of Connecticut and is offered as an example others may wish to adapt for use in their own communities.

Remember, the case assessment is the culmination of the initial investigative stage of an abuse or neglect case. At the end of the assessment the worker should know whether or not abuse or neglect is occurring and, if so, whether or not the risk is serious enough to warrant immediate intervention. General situations calling for immediate action include:

- maltreatment that could result in permanent damage to the victim.
- the client is in an immediate need of medical and/or psychological care.
- existing damage to the client is so extensive that he or she needs an immediate change in environment to recuperate.
- the abusing or neglecting party is so incapacitated that he or she is unable to care for the client's basic needs.

Case Referral

For those unable to handle abuse or neglect cases themselves, referral to social service agencies is a frequent form of intervention. Agencies to which cases are most often referred include:

- mental health clinics
- in-home care providers
- hospital social service departments
- family service agencies
- visiting nurses associations
- public welfare departments
- legal services programs

Referral may or may not result in a serious effort to address a problem, depending on the focus of the agency and its resources. In general abuse and neglect cases require a case manager and a case plan. The referring party should be aware of this fact. Too often the referral is just another form of neglect. The Battered Elder Syndrome indicated that in 95% of the abuse and neglect cases reported the victim or the abuser requested some form of help that was not provided. Follow-up by the referring party is a procedure owed a client, particularly one as vulnerable as a neglected or abused older person.

Tips on Case Management and Case Planning

If the assessment reveals abuse or neglect, it is necessary to develop a case plan for the client and a procedure for managing that plan unless the client rejects all forms of assistance. The plan and the implementation of the plan will vary greatly depending on the client's situation, the worker's role, and the resources available. Homemaker services or a meals program may be enough to reduce the burden on the caretaker and solve the problem. At the other end of the spectrum, placement in an institution such as a nursing home may be the only realistic solution.

In general the case manager's role falls into four areas of activity:

1. Problem identification and review of the client's assessment
2. Case planning and referral
3. Service facilitation
4. Follow-up

The case manager must review the client assessment or make the initial client assessment depending upon when he or she receives the case. After assessment, the case manager must develop a comprehensive case plan with necessary referrals. As part of this process the manager should identify the client's problems; inventory the community's resources; and match community resources with client needs. This is easier than it sounds in abuse and neglect cases. As a rule, they demand innovative solutions. And as with any kind of case planning, knowledge of community resources is most valuable. For example,

a worker confronted by a retired, disabled serviceman who is almost certainly being exploited by a family member will not have any particular community resource as a referral. S/he might, however, try to introduce the client to an assertive, alert retired serviceman recruited for "friendly visiting" from the local Disabled American Veterans post. The more assertive man might be able to assist the exploited client better than the assigned case worker, at least initially. Unless a client is willing to admit that s/he has been victimized, case planning which directly deals with the abuse or exploitation is probably less useful. Finally, case planning is rarely a "one shot deal". It is an ongoing process which should involve the client in key decisions.

The case manager's role as service facilitator is largely one of coordination. Referrals most often go awry (especially in compelling abuse cases) because roles and responsibilities of various service providers are not clear. Few cases can assume such tragic proportions as those that end with an angry and confused client dismissing everyone because he or she feels lost in a field of competing "helpers". Make certain the client understands what services are being brought in and why. Try to involve the family to the extent possible. For clients with less ability to understand, the case manager must depend on the quality of his or her ongoing relationship with the client.

Follow-up may well be one of the most important roles a case manager can fill. Without follow-up, the clients can and do fall through the cracks of the best intentioned system. Set follow-up goals for each referral and let both the client and the service provider know what those goals are. A follow-up of this sort not only insures service for the client, it shapes the response capacity of service providers. Follow-up is a crucial element in abuse cases because it is an excellent way of demonstrating unfailing interest in the client's problem. It is essential to remember that case management follow-up will almost always have two distinct goals:

1. Service follow-up
2. Relationship follow-up

Because case management tends to focus mostly on securing and monitoring services, it is worthwhile to consider two increasingly accepted concepts about domestic abuse:

a. Persons abused, regardless of age, gender, race or economic status, tend to be "other excluding." They are not just isolated and alienated, but in some instances they work at being isolated.

b. The intervention strategy which seems most effective over time is one which uses a relationship rather than intensive counseling.

The implications of this for case managers is clear. In cases of victimized elders, an ongoing semi-therapeutic relationship may have greater long-term benefits than any specific service. This relationship need not be the full responsibility of the case manager and it is possible that such relationships might follow from case management referrals to other providers.

Placement Outside the Home

In The Massachusetts Survey, the single remedial action most often taken or recommended was placement in a nursing home, hospital, temporary housing situation, or mental health facility. In cases of emergency, removal of the victim from the home was recommended 50% of the time. However, there is no clear evidence that less restrictive alternatives were carefully explored. Placement may end the abuse or neglect but run counter to the victim's wishes and best interests. The victim may prefer to stay with family members rather than live in the usually restrictive and sterile environment of an institution. Barring imminent threat of serious harm or the clear preference by the client to move, the worker should explore what a carefully designed package of services delivered to the home could do to ameliorate the problem before recommending removal and institutionalization. In many cases such a package can reduce the caretaker's stress below the level that is causing the abuse or neglect.

The worker should also be aware of a number of alternatives to traditional institutionalization that are being developed. These include:

- day care to relieve the stress on both the victim and the caretaker.
- respite care (temporary overnight shelters) to provide a cessation of abuse or neglect and to allow for a cooling-off period and safe evaluation.
- foster care to provide a "new family" context comparable to that available to abused children.

Unfortunately these services are usually unavailable. Those considering effective programs in the area of elder abuse and neglect should give careful consideration to establishing and providing such services.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
Protective Services for the Elderly

CLIENT EVALUATION AND FUNCTIONING

Client's Name _____ Age _____ Sex _____

Client's Address _____ Race _____

----------PHYSICAL ENVIRONMENT----------

Neighborhood: _____

Shelter: Sound_____ Deteriorating_____ Dilapidated_____ Water_____

Electricity_____ Heat_____ Toilet_____ Food_____ Stove_____

Housekeeping: _____

Hazards: _____

Other observations: _____

_____

----------SOCIAL ENVIRONMENT----------

Isolated_____ Known and visited by neighbors_____ Relatives_____

Household composition: _____

_____

----------PERSONAL APPEARANCE----------

Dress:_____ Facial Expressions:_____

Gait:_____ Gestures:_____

Posture:_____ Speech:_____

----------PHYSICAL HEALTH----------

Client-defined problems: _____

_____

_____

[Indicate duration of problems:]

Malnourishment_____
Lumps_____
Persistent Cough_____
Severe Headaches_____
Vomiting_____
Change in bowel habits_____
Blood in urine_____
Vaginal bleeding_____

Open sores_____
Sudden weight loss_____
Severe chest pain_____
Shortness of breath_____
Dizziness_____
Vision impairment_____
Hearing impairment_____
Other_____

Most recent vist to doctor_____ Next medical appointment___ ___

Recent medical problems:_____

_____

Medications_____

Comments:_____

_____

----------MENTAL HEALTH----------

Client-defined problems:_____

_____

[Indicate duration of each problem:]

Loss of appetite_____
Insomnia_____
Feelings of worthlessness_____
Loss of interest_____
Hypochondria_____
Suspiciousness_____
Hallucinations_____

Delusions_____
Thought distortion_____
Confusion_____
Impaired judgment_____
Memory lapses/loss_____
Orientation_____
Other_____

Hazardous behaviors_____

Alcohol or other drug use_____

Recent losses of family or close friends_____

Past mental health problems_____

Capacity to consent_____

Other comments:_____

_____

----------CLIENT MOBILITY----------

Bedridden_____
Partially bedridden_____
Wheelchair_____
Housebound_____
Able to get to yard_____
Neighborhood_____
Public transportation_____
Drives car_____
Other_____
Comments:_____

_____

--------PHYSICAL COMPETENCE---------

Feeds self_____
Bathes self_____
Dresses self_____
Uses toilet_____
Gets out of bed_____
Light housework_____
Climbs stairs_____
Goes outdoors_____
Cooks_____
Shops_____
Heavy housework_____

----------ECONOMIC SITUATION----------

Income _____ Resources _____

Expenses _____

_____

_____

Affairs managed by _____

Comments _____

_____

_____

OTHER HELPING PERSONS OR AGENCIES INVOLVED [specify involvement]:

_____

_____

_____

CLIENT'S PERCEPTION OF PROBLEMS: _____

_____

_____

_____

WORKER'S PERCEPTION OF PROBLEMS [specify nature of protective problem]:

_____

_____

_____

RECOMMENDED ACTION: _____

_____

OBSTACLES: Does client consent? _____

Is client's ability to consent questioned? _____

Other: _____

EMERGENCY: _____

_____

_____

Worker's Name

Date completed

I, _____, authorize the Department of Social Services to provide the services they may deem necessary to insure my safety. I agree to reimburse the Department if it is later determined that I am to pay for the services provided.

_____ _____ _____

Witness's name Applicant's name Date

CHAPTER 5

LEGAL ISSUES AND REMEDIES

Cases of family violence raise fundamental and complex issues of privacy, confidentiality, access to the victim, protection of the victim from further harm; restraint, punishment or rehabilitation of the assailant; and possibly issues of the mental competency of both the victim and the abuser.

Most victims fail to report their plight or are unwilling recipients of assistance to prevent further harm. These client characteristics pose immediate and difficult legal and ethical issues for workers investigating and assessing cases of elder abuse. Two issues confronted initially are the client's right to privacy in the home and the client's right to have information about him/herself held confidential.

Access to the Abuse Victim

The question of access to persons living in private residences is a key issue for workers with clients who are suspected abuse victims. Under the laws of most states, there is no legal authority for a worker to gain access without the consent of the elderly person or the caretaker. Traditional trespass laws govern.

There have been many reports of elder abuse cases which raise the issue of access. Because this legal constraint at times causes difficulty in outreach and service provision, some social workers have come to rely on gaining access through homemakers, housing inspectors, or meal providers. Such intervention relies on deception and a betrayal of confidentiality and is inappropriate. It violates the individual's right to privacy and creates the potential of civil liability for the social service worker and his/her agency. In addition, it may destroy or prevent the development of any trust between the client and the worker.

There is often a conflict between the humane impluse to provide services and the individual's right to refuse services or even access. This conflict raises questions such as:

- Does a person have a right to remain in a dangerous environment if s/he wishes?
- Must s/he be left exploited or neglected, even to the point of starvation, if s/he chooses?

The following is a brief analysis of issues raised by this conflict.

First: Basic to our legal system are the individual's right of self-determination and right to privacy. These constitutional rights are an expression of the sanctity of individual free choice as a fundamental constituent of life.

The individual's civil rights are not absolute or without limit. The state (and its agencies) can and does intervene, regulate, and prohibit. State intervention occurs pursuant to two legal doctrines:

- Police power, which gives the state authority to regulate activities that involve the health and safety of society.
- Parens patriae, which gives the state authority to act in a parental capacity for persons who cannot care for themselves or who are dangerous to themselves.

Intervention by the state is regulated by balancing the state's interests (under the police power or parens patriae doctrines) against the interests of the individual to be left alone. In child abuse reporting statutes, the states can intervene in the life of a family because it has an overriding interest in the health and welfare of the child.

The parameters of state intervention are often unclear, reflecting historical and social trends. When the state does have the right to intervene in individual lives (under health regulations, social welfare laws, etc.), that right is defined specifically by statute and regulations. The state does not have the right to intervene in a person's life without either the person's consent or statutory authority. Such limitations on state intervention serve to protect those individual rights we value.

Second: The competent person has the right to refuse social and medical services:

- The highest court of Massachusetts held in Lane v. Candura (1978) that, if an elderly woman was competent, she could make her own decision concerning the refusal of "needed" medical treatment, whether or not that decision might seem irrational to others. The court found that Mrs. Candura was competent. The evidence showed that she tended to be stubborn, that she was lucid on some matters and confused on others, that her train of thought wandered, that her conception of time was distorted, that she was sometimes hostile, occasionally defensive, and sometimes combative to questioning, but that she had a high degree of awareness and acuity. The court said that irrational did not mean incompetent.

The right to refuse services can be limited if the individual is found to be legally incompetent. Under most state laws, limitations on the individual's right to self-determination require the state to present sufficient evidence to meet the statutory criteria for appointment of a guardian (i.e., the individual is unable to care for his/her basic needs or to make responsible decisions concerning him/herself) or for civil commitment to a mental health facility. Such determinations are only allowable with full due process protections, including the right to counsel.

In a judicial determination of the individual's competence, the court relies on evidence, testimony, the persuasiveness of argument by the attorneys, and other, often intangible, factors such as the inability to think or act for oneself as to personal health, safety, and general welfare, or to make informed decisions as to property, finances, etc.

While state guardianship statutory standards may be similar (many states use the Uniform Probate Code), case law interpreting the standards varies from state to state, and in some instances form community to community. Recent cases have addressed whether one who is "insane" but able to care for basic needs such as food, clothing, and shelter can be forced to have a guardian. At least one state Supreme Court has denied guardianship in such a case. Whether the same reasoning would apply in other states or in a case where someone chooses to remain in an abusive environment is unknown. It is clear that the "competent" (i.e., non-insane, able to care for oneself) individual can make an irrational decision to remain in an abusive environment.

Third: The authority to intervene when services are refused is limited.

- If services are refused, a social services agency has no legal right to intervene without a showing of incompetence.
- Even if the individual can be proved incompetent under the often vague standards of state law, a person willing to be a guardian must be located. Finding such a person is often difficult. Some states do have an Office of Public Guardian to deal with such cases.
- If access to the home is denied, access cannot be gained unless there is an emergency (a fire, someone calling for help, etc.). In some cases (e.g., a health inspection), a warrant or other court order is necessary.

- In a suspected abuse case where the apparent victim has not complained and access is denied, no legal action can be taken without evidence and/or a witness. If there is substantial evidence and/or a witness, a criminal complaint is a possible - but not necessarily good - alternative.

Fourth: Many states have recently enacted adult protective services statutes that make reporting adult abuse mandatory.

- Despite these laws, intervention is still prohibited if the elderly person refuses services. In some states, broad powers to provide services to involuntary clients are set out. The standards and procedures of these laws vary from state to state and, in some cases, pose significant threats to the civil liberties of the elderly.

Confidentiality of Client Information

A second fundamental aspect of the right of privacy is the client's right to confidentiality concerning anything the worker learns about the client's situation.

Federal law and many state laws now prohibit the divulging of information obtained from a client which would serve to identify that client. These statutes and regulations require that a social service agency seek and obtain the consent of the individual before making a referral, discussing a case with other agency staff, or instituting a case plan.

The client's right to privacy of information concerning his/her case is now defined by statutes and regulations which vary from state to state. Protected information generally includes any data contained in case files or computer files, including information concerning the client's medical, social, psychological, financial, and vocational situation.

Most states require that before this information may be released by the client's worker to anyone other than the worker's supervisor, the client must give informed consent for its release. Such consent, to be informed, requires that the client be informed as to what information is to be released, to whom, for what purposes, and with what possible consequences. The client must receive this information in a form comprehensible to him/her and must indicate clear understanding and agreement. Such consent must be overt, i.e., a clear statement given verbally or, preferably, in writing - it cannot simply be implied.

Most states now provide fines and/or jail penalties for unauthorized release of confidential information. In addition, a client in most states has a right to sue for damages for unauthorized release of confidential information.

Privacy rights are easy for workers to adhere to in the abstract. In practice, workers must exercise real restraint in conducting case assessments and doing fact-gathering if they are not to violate the client's rights to privacy and confidentiality. The laws clearly mean that a client has a right to determine with whom a worker discusses the case. While such a requirement may seem inhibiting to some workers, most workers agree that good casework requires trust between client and worker, and that privacy and confidentiality laws are supportive of developing and maintaining such trust. Disregard of client rights should not be rationalized by any notion of working in the "best interests" of the client.

Criminal Court Remedies

Abuse of an elderly person constitutes a crime. Depending on the facts, an elderly person who has been physically abused or exploited can file a complaint charging assault, assault and battery, assault and battery with a dangerous weapon, blackmail, extortion, etc. One must ask whether reliance on the criminal justice process is an effective approach in most cases of elder abuse.

The criminal justice system requires that the elderly victim be willing not only to file a complaint with the district attorney, but also to testify in court. One of the clear findings in the research done on elder abuse is that victims are most often harmed by family members. Thre is further evidence that victims often do not want to get the family member in trouble and therefore are unwilling to use the criminal justice process.

The disposition of a criminal complaint involving domestic violence depends upon the facts of the case. The variables examined include the extent of the injuries, whether this is a first offense, who the parties are, who the judge is, the testimony of the victim, the objectives of the district attorney, mitigating circumstances, etc.

Experience in spouse abuse cases indicates that many criminal trial court judges, relatively less experienced and less sympathetic to domestic matters traditionally handled by domestic and probate courts, prefer to rely on reconciliation as a solution to abuse, rather than to use the power of a criminal court to "protect" the victim by imposing criminal sanctions. The judges often believe that such sanctions will destroy a family that otherwise might be saved. Even in cases where criminal sanctions are appropriate, some judges may consider the expenses society will have to bear to sustain a dependent adult outside the home and push reconciliation instead, leaving the victim more at risk than ever.

In general, judges adopt a lenient attitude toward the defendent in a criminal case where the injury is not extreme or is a first offense. Thus, quite soon after filing a complaint, the abuser will probably be released - either outright or on probation. One can speculate that the abuser will then return home to the elderly person. The increased antagonism may well cause another incident of abuse. Because a protective order is not issued in conjunction with the criminal justice process, the elderly person has no form of immediate protection upon which to rely other than the inadequate choice of reporting a probation violation or filing another complaint with the district attorney. The probation process cannot serve to assure the elder's physical safety because it does not call for police enforcement or protection. Let it not be misunderstood that protective orders issued from civil courts are necessarily effective or even enforced. The incidence of police non-response is well-known. But in order for this to change, utilization of such orders and insistence on their enforcement is needed.

In cases of extreme violence and injury, a criminal complaint may result in a long prison sentence. Clearly, this removes the abuser from the household. But, again, this remedy is not linked to providing a substitute for the caretaker/abuser. Nor is there linkage with service provision necessary to assure the welfare and potential self-sufficiency of the individual. Thus, the criminal justice system, functioning in isolation from service provision, inevitably fails to correct the underlying causes or to provide protection and support services most essential to the person in need.

In most states until the 1970s, restraining orders were not available for cases of domestic violence unelss a divorce or separation petition had been filed. This remains true in some states today.

Where this is the situation, civil relief for victims of elder abuse is virtually non-existent. Since most victims of elder abuse are not abused by spouses, a restraining order cannot be obtained because no divorce petition can be filed. Even if the spouse is the abuser, the victim may desire protection but not divorce.

As of July 1980, thirty-four states had enacted laws providing for the issuance of restraining orders against domestic abusers. The laws are usually referred to as Domestic Violence Acts or Adult Abuse Prevention Acts. Most of the statutes create new civil and sometimes criminal remedies for persons abused by family or household members. Some laws specify the powers and duties of police who answer domestic disturbance calls. Some require agencies offering services to violent families to keep records or write reports on family violence. Most importantly, many state legislatures have appropriated funds for shelters and other services to victims of violent families.

While the statutes vary, the following are characteristics of some of the currently operating domestic violence state laws:

- The law applies to abuse, not normally to neglect or exploitation.
- Abuse is generally defined as attempting to cause or causing physical harm, placing another in fear of imminent physical harm, or causing another to engage involuntarily in sexual relations by force, threat of force, or duress. (Definitions of abuse vary according to the state statutes.)
- Any child or adult may bring a court action against a household member, a spouse, a former spouse, or blood relative. Thus, an elderly person living with a family member or friend can use such a law, but the victim is the only person who can file - not a friend or agency worker.
- The action is initiated by a civil, not a criminal, complaint.
- The relief which may be obtained is a protective or restraining order against the abuser requiring that person to stop further abuse.
- In some states a vacate order may also be obtained which requires the abuser to move out of the house, regardless of who owns it or pays the rent.

- Violation of an order is contempt of court and therefore a criminal act. This subjects the abuser to arrest and a fine or jail term.

- Some states also require the abuser to pay for losses suffered by the victim as a result of the abuse. This may cover medical bills, moving expenses, loss of earnings, rent or mortgage payments, and attorneys' fees.

- Court filing fees, use of a lawyer, and complicated petitions have been eliminated in some states for persons filing actions for protective orders.

- In all but emergency cases, the victim/petitioner must give notice to the alleged abuser/defendant before a court hearing will be held on the matter.

- If there is immediate danger of abuse, or if notice will endanger the safety of the victim, the victim can seek an emergency temporary court order without giving prior notice to the abuser.

- Emergency petitions in some states will be heard by the courts within hours of being filed, 365 days a year, day or night.

- If an emergency order is issued, the defendant has an opportunity for a hearing to contest it within a few days.

- Many laws require police to take specific actions to prevent further abuse if the officer has reason to believe that the person has been abused or such abuse is imminent. This includes remaining on the scene until the danger has been eliminated, assisting the person to necessary medical care, giving notice of rights to the victim, and arresting the abuser in certain cases.

Lawyers and courts are intimidating and confusing. Often the elderly person will not agree to seek a legal remedy. If the victim is willing to go to court, the remedies available through the judicial process are often inadequate. Removing the caretaker from the home does not necessarily make the social service system able and willing to compensate for the lost support and assistance. Shelters which have been established to provide alternative housing for abuse victims often cannot meet the needs of the disabled or more dependent elder.

The difficulty with the statutes, then, usually lies with the lack of a mandated in-home supportive services system necessary to supplement or replace the caretaker for elderly abuse victims. State legislatures should be made to realize that dependent, vulnerable elders may be seeking remedies under these laws and that they have special service needs.

Those thirty-four states that already have domestic violence statutes should evaluate their resources and consider mandating programs that specifically provide the needed services. States without domestic violence statutes should consider enacting statutes that include provisions establishing the necessary in-home and other supportive services.

Even with their limitations, domestic violence laws have opened up new possibilities for an elderly person who is able to make the necessary decision to seek protective orders.

Protective or Surrogate Remedies

A frequent mistake in the handling of elder abuse or exploitation cases occurs when workers encounter a competent victim who will not consent to take action to prevent further harm to him/herself. Workers frequently conclude that refusal to accept assistance is a sign of irrational behavior which requires appointment of a guardian or other surrogate to care for that person. Adhering to the principle of the least restrictive alternative, workers should analyze the client's incapacity by first asking the following questions:

- Is the incapacity something that could be alleviated by medical attention?
- Can the incapacity be compensated for by support, advice, assistance from supportive services available in the community?
- What is the least restrictive alternative? Each person has the right of self-determination. Any limitation of that right should be the minimum necessary. Guardianship reduces the elder to a legal status comparable to that of a child.

The following alternatives to guardianship may be appropriate, depending on the facts of the situation. The alternatives are listed in order of increasing formality and loss of control by the person subjected to them.

- Direct Deposit. Federal benefits (Social Security, SSI, VA, etc.) can be deposited into the client's bank account directly. This simple mechanism may prevent theft of checks. This arrangement is set up by the client and bank.

- Joint Bank Account. No court order or other proceeding is required. Both parties simply sign authorization cards for the bank. Either party has the legal right to the entire contents of the account.

- Restricted Bank Account. These include co-signatory accounts requiring two signatures for withdrawal and accounts with permanent withdrawal orders (i.e., the bank issues a monthly allowance to the individual).

- Power of Attorney. No court proceeding is required. Written authority is generally necessary. This device confers power to another to sign documents and act on behalf of the elderly person, a power terminated whenever the client wishes. It is best to include accounting provisions, termination date, and specific description of powers conferred. A power of attorney is usually automatically revoked by incompetency, mental illness, or death, except where "attorney" did not have actual knowledge and acted in good faith. One need not be a lawyer to receive power of attorney.

- Representative (Substitute) Payee for Social Security. Social Security regulations (20 C.F.R. 404 §§ 1601 et seq.) provide a mechanism for another person to receive a beneficiary's check. The standards are very loose ("in the best interests of the beneficiary...") for such an appointment. The beneficiary can request that a representative be appointed. The representative payee must use the money solely in the interest of the beneficiary and must make periodic accounting to the Social Security Administration. Similar provisions exist for handling federal Veterans benefits and for Supplemental Security Income.

Each of these options has disadvantages as well as advantages. Each can help solve a problem, or, when the wrong person is involved, create an opportunity for financial exploitation. Legal assistance should generally be sought in setting up one of the money-management devices, and always in any case of suspected exploitation.

When none of these options will remedy the problem, then conservatorship, guardianship, and civil commitment must be considered.

- Conservatorship. A conservator is appointed by a probate court judge after a hearing. Most state conservatorship laws state that a conservator can be appointed if a person is unable to properly care for his/her property due to advanced age, mental weakness, or other disability. This is an appropriate remedy in a case of exploitation if the victim lacks the capacity to manage his/her property. Note that the financial management services discussed above can be utilized only when the victim possesses the capacity to manage property. A conservator generally receives control over the person's property and finances, not over other areas of the person's life.

  In many cases of abuse, financial difficulties and conflict may be a major source of stress. Removing this stress by placing financial control in the hands of uninvolved persons may result in dissipating the potential for abuse. There are a number of reported cases in which a relative was appointed conservator and proceeded to divert funds to his/her own use.

- Guardianship. A guardianship is also appointed after a hearing in probate court. At the hearing, it generally must be established that the proposed "ward" is incapable of taking care of his/her basic needs due to mental illness or other disability. If this is established, usually through medical or psychiatric testimony, the court declares the person to be legally incompetent and the guardian assumes control of his/her personal affairs. In many cases the guardian will also be appointed as conservator - that is, controller of the ward's financial affairs. Where the ward has a small estate, guardianship itself implies some control over the ward's finances to the extent necessary to meet his/her basic needs.

  Guardianship is a drastic remedy in that it almost completely removes the ward's right to self-determination and autonomy. In most states, a guardian can place the ward in a nursing home against the ward's wishes.

  Guardianship is appropriate only if the individual is totally unable to care for him/herself or cannot make responsible decisions concerning his/her life and welfare. As a remedy for abuse, it allows another person with surrogate authority to remove the ward from an abusive environment or to file an abuse prevention petition on the ward's behalf.

Appointment of a guardian rarely constitutes the least restrictive legal device for most persons in need of protective services. Social Service agencies often encourage guardianships as a means of "giving" services that the elderly person refuses to accept. Thus, it can be a tool to enforce the social service agency's notions of the "best interests" of the client. In such a case, competency and ability to care for oneself are not the real issues. Often the courts rubberstamp a physician's opinion without a full and impartial hearing rigorously applying due process and other legal standards.

- Civil Commitment. This is the judicial process by which a person is involuntarily placed in a mental institution. Civil commitment statutes generally require a finding that:
  - The individual is mentally ill;
  - The individual is dangerous to a degree such that failure to confine would create the likelihood of serious harm to the individual and/or to others; and
  - Commitment is the least restrictive alternative.

  Civil commitment is the most drastic alternative and should only be used as a remedy in an abuse case where these three factors are proved beyond a reasonable doubt and where there is an indication that the person will receive treatment once s/he is committed.

The preceding sections of this chapter have discussed various legal issues and remedies in handling cases of elder abuse. Two points should be remembered:

- Legal remedies by themselves are rarely sufficient.
- They can make matters worse.

The law is a rough tool; legal remedies are often not appropriate remedies in cases of elder abuse. Sensitive social case work is more likely to succeed in most cases than is use of the law.

Finally, it should be noted that most of the laws discussed above vary from state to state. Anyone working in elder abuse should take the responsibility for finding out exactly what the relevant state statutes say. Usually, this means consulting a lawyer familiar with these areas of law.

CHAPTER 6

PROTOCOLS FOR HANDLING CASES

Two basic roadblocks which impede effective treatment of victims of elder abuse are:

- The inability to gain access to and cooperation from victims.
- A lack of medical, social service, mental health, and legal personnel trained to treat cases of elder abuse.

The first problem involves the victim's rights to privacy and self-determination, as well as the victim's possible ignorance about available remedies. The second involves the lack of preparedness by the community to help victims of elder abuse.

The first problem may or may not be solved, depending upon the victim's willingness to be helped. The second problem definitely can be solved. Solving the second problem is often essential to solving the first.

Purposes of the Protocols

The protocols introduced in this chapter have four purposes:

- To serve as a pathway for workers to follow in handling individual cases of elder abuse.
- To highlight the interagency and interdisciplinary co-operation which is needed in an effective community response system for handling elder abuse cases.
- To provide a case management process to be followed in assessing, evaluating and developing a case plan for elder abuse cases.
- To serve as models for other agencies to use in developing their own case protocols, e.g., hospital emergency rooms, visiting nurse associations, police departments, etc.

Four Categories of Elder Abuse Cases

Individual victims of elder abuse are not susceptible to easy classification. The uniqueness and variety of the cases do not mean that there are no common characteristics. Legal Research and Services for the Elderly created four categories of elder abuse cases that have proved useful in understanding, assessing and planning for victims of elder abuse. These four client categories then served as the basis for developing case protocols.

These four basic client categories of elder abuse are:

1. Competent, consenting client: the client who appears to be mentally competent and who consents to assessment and assistance.

2. Competent, non-consenting client: the client who appears to be mentally competent and who may refuse assessment and does refuse assistance.

3. Incompetent client: the client who (regardless of his/her degree of cooperation) appears to lack sufficient mental capacity to make informed decisions concerning his/her own care.

4. Emergency client: the client who is in immediate danger of death or serious physical or mental harm, and who may or may not consent to help and may or may not be mentally competent.

These four categories have as their point of reference the client's right and ability to determine the system's response to his/her problems. The client's rights and wishes will bring the protective services system to a halt, time and time again, unless pre-planned responses are available for each client type.

Workers who have attended training sessions held by LRSE staff have often spoken of their feelings of helplessness when confronted with suspected victims of abuse who refused assessment and services. Concerns over protecting clients' rights in potential guardianship situations and questions about the proper use of legal representation for agency staff and clients in such situations were often expressed by workers. These problems can be lessened and in many cases solved if agencies have a list of steps and time frames which should be followed when workers are confronted with such situations.

Case Protocol Format

The protocols follow the same basic format, as outlined below:

- Type of client
- Characteristics of such a client.
- Outline of case plan.
- Initial case contact.
- Initial case assessment.
- Case evaluation and case plan development: general considerations.
- Case evaluation and case plan development: specific considerations.

The protocols discuss social work techniques for assessing and handling cases. Legal issues concerning the particular type of victim are reviewed. Financial, housing and support services issues are also examined.

For purposes of this manual, the protocols do not refer to the laws of any specific state. Therefore, when dealing with a particular legal issue, a worker should seek legal counsel in his/her state.

CASE PROTOCOL #1

Type of Client: Competent, consenting client.

Characteristics of client:

- The person is an alleged or actual victim of abuse, neglect, exploitation, or abandonment. (These four are hereafter referred to generally as "victimization" and the term "abuser" will generally refer to persons responsible for any of the four types of victimization.)
- The person is legally competent, and has not been adjudged incompetent by a court of law and/or has not had a full guardian appointed to oversee his/her life or assets. Nor has the client been committed to an institution by a court of law.
- The person understands what has happened to him/her and desires to take action to halt further victimization.

Outline of a Case Plan

Initial Case Contact: A worker in a community agency receives a report of, or uncovers a case of suspected abuse, neglect, exploitation, or abandonment. This report will, in all likelihood, be from a third party and not from the victim.

Initial Case Assessment: The worker contacts the victim/client to discuss the problem, verify the reported victimization, gather further information and discuss methods for resolving the problem.

The worker should remember that the client has the right to reject any unwanted intrusions into his/her life and that this initial case assessment visit may be considered such an intrusion. The worker should use all of his/her skills to make the client feel that the initial assessment is a positive interaction.

If the client refuses to have anything to do with the worker and expresses a desire to be left alone, the worker must respect this right to privacy. The worker should receive a clear indication from the client that he/she wishes to proceed with the case before proceeding further.

The worker should also remember that the client has a right to privacy and confidentiality concerning anything discussed with the worker. Before proceeding with further investigations and interviews with other parties, the worker should request and receive permission to do so from the client (in writing, if possible).

If the worker has already determined that he/she will not be the primary worker on this case, then he/she should discuss this with the client and clearly indicate that another person will be contacting the client in the near future on this matter. This transfer of worker responsibility is critical and should be handled with great sensitivity to the client's needs. The initial worker should thoroughly brief the new worker on the facts of the case and accompany the new worker on the first visit.

Information which the worker should attempt to elicit from the client at the initial meeting includes the following:

- Health condition and name of client's doctor or primary health care facility.
- Sources of income.
- Family members.
- The nature of the living arrangements, e.g., who owns home or who pays the rent.
- Whether the person has friends nearby who might be available to provide assistance or support.

Case Evaluation and Case Plan Development: General Considerations

Case evaluation and case plan development follow a determination by the worker that the client is a victim of abuse, neglect, exploitation, or abandonment. This step may begin at the time of the initial case assessment described above, depending upon whether the worker initially involved in the case will handle it throughout or will be transferring the case to another (specialized) worker.

Case evaluation consists of a complete investigation and analysis. The development of a case plan is based upon this evaluation and may actually include the development of two or three potential plans which will be discussed with the client. These plans should be based upon the premise that there are likely to be a number of possible responses to actions taken by the client and worker and that contingency plans need to be available.

The case evaluation should, of course, be conducted by the primary worker on the case, probably the protective services worker if one is available. With the client's agreement, the worker should seek

additional information concerning the client's problem from other persons who know the client. These persons might include other case workers, the client's physician, visiting nurse or mental health worker, senior center or nutrition site staff, and neighbors or friends. In addition, the worker may at this point wish to consult with a formal protective services committee which may have been established in the area in order to complete a thorough assessment of the client's status. This fact gathering and analysis process should provide the information needed to develop the case plan(s).

The development of a case plan, as indicated above, consists of a number of alternative courses of action which may be pursued with and on behalf of the client. In developing the case plan, the worker will probably want to draw upon the knowledge of the local protective services committee, if it exists, or, alternatively, may wish to consult with a physician, nurse or mental health worker, a lawyer, or another protective services worker.

If legal advice is sought, the worker should be certain to consult with an attorney who is <u>not</u> likely to be called upon to provide legal advice or representation to the client on the same problem at a later date. This is important because a lawyer may only represent one person in a given case, and the worker and client do not necessarily share the same interests at all times. Legal advice which the worker may require includes:

- The definition of competency under the guardianship laws and whether the client appears to be competent under that definition.
- How to petition for a guardianship or conservatorship.
- Whether criminal acts have been committed.
- Possible alternative legal methods of handling cases of financial exploitation.
- The implications of using a domestic violence statute.
- What the worker's liability may be in investigating the case.

Once case plan alternatives have been developed, the worker should again meet with the client (or talk on the telephone, if a meeting simply is not possible) to discuss the alternatives. This is obviously a critical point in the worker/client relationship. The worker needs to be especially supportive, sensitive, patient, and lucid in presenting alternatives and likely outcomes. The client's right to self-determination should be the primary consideration at this point. A clear agreement should be reached as to the next steps to be taken.

Case Evaluation and Case Plan Development: Specific Considerations

In conducting the case evaluation and developing case plan(s) for a competent, consenting client the following specific considerations need to be examined:

Existence of Victimization

The incident(s) of victimization needs to be verified and additional information obtained. Witnesses help but are not absolutely necessary if the client is competent and willing to act on his or her own behalf.

Competency of the Individual

If the client does not have a guardian or has not been legally committed to an institution and clearly can function in daily life without threat to him/herself, then the client is almost certainly competent. Therefore, use of guardianship or commitment procedures need not be considered by the worker as possible remedies for the victimization.

Some workers forget this in difficult cases and return to guardianship as a possible remedy because all other alternatives appear impossible. This is a rather self-defeating behavior on the worker's part.

The questions for the worker, then, are:

- Is the victimization which has occurred the type of action for which civil or criminal relief may be sought with expectation of success?
- If so, does the client/victim wish to make use of this remedy now?
- If the answer is yes to the two previous questions, what precautions should be taken with the client before actually seeking the court's help - e.g., to make sure the client is not alone with the abuser when notification of the court action is given to the abuser?
- What support services will the client need once the court order is obtained and the abuser is restrained and/or removed from the house?

Some clients will be ready to use legal action and may proceed with a lawyer. In most states there are elderly law projects, and the client may obtain free legal assistance from those programs.

If the client is not prepared to utilize legal remedies initially, two points should be remembered. First, only the victim can file complaints with the court; the worker or a friend cannot file the complaint on behalf of the victim.

Second, while the client may be unwilling to use this remedy initially, s/he may be willing to do so later. The worker may therefore wish to raise this possibility again at a later date.

If the client does wish to make use of a legal remedy, the worker, client, and the client's lawyer, if one is obtained, should develop a complete strategy. A decision should be made as to what relief to seek. Based upon that decision, plans should be made to assure the safety of the client prior to and immediately after the complaint is filed and the abuser receives notice.

These plans may include:

- Arranging for temporary housing for the client.
- Arranging for the worker or another person to stay with the client for a period of time.
- Arranging for the client's lawyer or a police officer to be present to persuade the abuser that the court action is a serious matter.

Before seeking a court order, the worker, client, and client's lawyer should be confident that they can get the court to agree to issue the order and that they can arrange whatever services will be needed. This, again, may involve:

- Locating temporary housing for the client.
- A conversation between the client's lawyer and the abuser concerning the complaint.
- Identification of additional emergency financial resources for the client.

Financial Issues

Money is a critical concern in most cases of elder victimization. Possible remedies for the problem may also include arranging for some financial protection for the client/victim.

Many cases of abuse appear to result from pressures and/or arguments over money. Some cases involve the abuser's financial problems which are exacerbated by having to support the older person for whom the abuser is the principal caretaker. Other cases involve an elder victim who is subjected to abuse because s/he refuses to turn over funds to the abuser.

Typical cases involve so-called "friends" or family members who steal or extort funds from the older person. These cases sometimes involve physical abuse as well as exploitation.

The facts of the specific case will determine what alternative financial plans are developed. Certain steps should be taken by workers in most cases of abuse and/or exploitation and in some cases of neglect and abandonment.

Investigation and Analysis of Client's Income and Assets

Asking persons about their incomes and assets is a touchy subject and a clear intrusion into the person's private affairs. Such inquiries must be handled sensitively, discreetly and with proper explanation to the client as to why the worker wants the information.

In cases where there is financial exploitation, the worker and client should attempt to make a complete listing of all current income sources (SSI, Social Security, pensions, interest or dividends, etc.).

The worker should find out:

- When the income is delivered to the client.
- To whom it is sent, e.g., is the SSI sent to the client or a representative payee?
- What the current practice is for handling this income when it arrives, i.e., who cashes the checks.
- Whether the money is deposited in a bank or not.
- Whether the bank account is in the client's name.
- Whether it is a joint bank account, and if so, with whom.
- If someone handles the funds for the client, how the client obtains cash, and how the client gets an accounting of his/her assets.

- Whether a conservator or guardian handles all money matters.
- Who pays household bills normally and how.

It also makes sense for the worker to obtain information on the client's other assets. This might include the determination of:

- Who owns the house in which the client resides.
- What real estate the client owns and whether the real estate is solely or jointly owned.
- Whether there are stocks or bonds and, if so, in whose name.
- If there is a car, who is the listed owner.
- Whether the client has other real property.
- Whether the client has a safe deposit box and, if so, who has access to the box.

The above information may also be needed in certain cases of abuse and neglect in which a physical relocation of the client is likely. Financial information, if available, is also useful in solving cases of abandonment.

Most of the above information will be available from the client, but it may take a long time to develop a complete picture of the client's assets. A combination of direct questioning and careful notetaking during less directed conversations should produce much of the necessary data. The client's permission should be sought before others are contacted to fill in gaps in the client's financial history.

Case Planning Involving Financial Matters: When a Physical Move Is Necessary

Financial planning is critical in cases where the client may have to move to a new location. Planning should be designed to assure that the client does not lose income or assets as a result of the move, and that the client has sufficient funds to survive in the new location. The worker and client should take measures to assure that the following will occur:

- Regular income, such as SSI, Social Security, pension checks, etc., is sent to the new residence of the client or is directly deposited in the client's bank account (this may take a number of weeks prior notice in some cases).

- The client's portion of any bank account(s) is withdrawn and safely deposited elsewhere.

- The client discusses with a lawyer or bank the steps that should be taken to protect any jointly held assets.

- If the abuser/exploiter happens to be a representative or substitute payee, this designation is changed.

- A list of valuable personal property belonging to the client is compiled prior to the move and that property is removed from the home with the client.

If the client has virtually no income or fluid financial assets, the worker should make certain that temporary and/or long-term financial assistance is available at the time of the move. This may mean seeking emergency aid from churches, the Salvation Army, private agencies such as Family Service Associations, Catholic charities, Jewish philanthropic agencies, or the welfare department.

Financial aid may be needed for temporary or long-term housing, groceries, clothing, and medicine. If the client is eligible for SSI, Medicaid, and/or food stamps and does not currently receive these benefits, applications should be filed (with the client's consent). Federally-funded public housing for eligible clients may also be explored for emergency shelter. [See section on Alternative Housing, below.]

When Financial Exploitation Exists

When financial exploitation has occurred, a criminal act has probably been committed. If the client agrees, a criminal complaint may be filed by the client with the District Attorney's office. If the evidence warrants it, the D.A. will file criminal charges against the exploiter and will attempt to recover the funds.

In certain situations the client may file a civil complaint against the exploiter and attempt to recover damages equivalent to the funds taken. If the exploitation involves consumer fraud, the Consumer Protection Act may be used to seek damages, but the client must, once again, agree to file the complaint with the court.

A competent, consenting client may agree to utilize the legal remedies described above and the worker should assist the client in contacting a District Attorney, legal services office, or private attorney.

A competent, consenting client may not wish to take legal action of the type described above, but may wish to simply prevent further losses. In that case, the worker should consider the following.

Financial Remedies Not Requiring Legal Action

If the exploitation act involved the exploiter forcing the victim to sign over benefit checks, it may be possible to prevent a recurrence by having future checks sent directly to the bank for deposit or by having checks sent to a representative payee who will cash them and manage the funds. SSI, Social Security, and Veterans benefits may be handled this way.

While these measures will not ensure that cash held by the client is not taken by the exploiting person, these steps make it more difficult for the exploiter to obtain such funds and put the exploiter on notice that s/he is being observed. The worker should discuss with the client whether this type of action is likely to prompt the exploiter to retaliate in a violent or other manner. Strategies for protection should be discussed with the client.

If the exploiter is forcing the client to turn over cash from checks or bank accounts, then a variation might be tried. Funds could be deposited in a "co-signatory account" which requires two signatures in order to withdraw funds. This will place another roadblock in the path of the exploiter.

A conservatorship can be created even in cases in which the client is competent. This applies particularly to cases in which the client is physically incapacitated. Under this procedure, the person appointed conservator has responsibility for handling the ward's financial affairs in the best interests of the ward. Since this takes away a substantial portion of the client's liberty, it should only be used when other, less restrictive remedies fail and with the clear consent of the client.

If a conservatorship is sought, serious consideration should be given to petitioning the court for a temporary conservatorship for only such time as appears necessary to protect the client from the specific problem presented by the case and/or for a limited conservatorship which only allows control over specific financial affairs.

A useful course of action may be for the worker to discuss the situation, either directly or indirectly, with the exploiter in an attempt to convince him/her to cease. If the client agrees, the worker may request an attorney to attend the meeting as well, to further emphasize the serious nature of the matter.

When Abuse and Exploitation Are Both Involved

If the client is being abused and financially exploited, as is often the case, the remedies discussed above are appropriate. In addition, with a consenting client, a restraining order may provide a vehicle for obtaining relief. An order may be sought requiring the abuser/exploiter to vacate the home, to stop the abuse, and to stop cashing checks or taking funds from a joint bank account.

When the Conservator Is the Exploiter

If the exploiting person is a legally appointed conservator for the client, the above remedies may be appropriate. In most states, the worker may petition the probate court on behalf of the ward, assuming the ward consents, to remove the conservator. Legal counsel will be necessary to take this action, and the abuse or exploitation will have to be carefully documented.

Housing and Support Issues

Housing and support services need to be coordinated for the client in most cases of abuse, neglect and abandonment and in some cases of exploitation. If the abuse, neglect or abandonment appears to be related to family stress which is at least partly attributable to the physical and emotional burdens of caring for the elder, then alternative shelter and/or support services may provide a means for relieving some of that stress. If the only effective preventive measure appears to be arranging for a separation of the parties, then alternative housing and support service planning is required.

When Only Support Services are Needed

If the client and the abuser live in the same household or if they live apart but the client is dependent upon the abuser for assistance with tasks of daily living, and there appears little to be gained by physically separating the two parties, then the worker and the client should determine what supportive services

the client needs which might lessen the chances of further abuse or neglect. In order to do this, the worker should determine what support the client currently needs and what support the client currently receives from the abuser and from other persons or agencies. To make these determinations, the worker should attempt to talk with the abuser and with the service providers, if the client agrees to such further discussions.

The communication with the abuser may be a major step toward preventing further abuse or neglect. It may indicate to the abuser that s/he is not alone and that assistance is available.

Following these discussions, the worker should evaluate the supportive services which are available in the client's geographic area and are needed by the client. After discussing this with the client and reaching agreement on which services should be arranged, the worker and/or client should seek to obtain those services. To the greatest extent possible, the worker should have the client arrange for these services him/herself. Substituting dependence on the worker for dependence on the abuser is <u>not</u> a healthy turnabout.

Supportive services which the client may need include:

- Homemaker or home health aid
- Chore service
- Visiting nurse services
- Transportation
- Meals in the home or in a group setting
- Assistance with shopping
- Mental health counseling or therapy
- Recreational or group activities, and
- Church activities

In addition, the worker should attempt to communicate with the abuser, epecially if the victim and abuser are in the same household, about a services provision plan for the abuser. If it appears that counseling, therapy, alcoholism or drug treatment, or other such services are needed for the abuser, the worker should attempt to work with the abuser to arrange for such services.

When Alternative Housing is Needed

An alternative living situation may be required for the client in cases of abuse, neglect, abandonment and in some cases of exploitation. Physical moves for clients should be viewed as the least desirable alternative since such moves usually require the client to sever long-standing personal relationships as well as emotional ties with home and possessions. Some research suggests that such moves increase risks of mortality.

Short-term alternative housing may be necessary if the victim obtains a restraining order and/or vacate order against the abuser. Temporary removal of the client will ensure that s/he does not have to be in the home when the order is served on the abuser and will provide some short-term client protection against possible retaliation. Temporary housing might be found in the home of a relative or friend of the client, in a motel or hotel, or in a temporary shelter for men or women who are victims of spouse abuse.

While public housing authorities do not currently treat elder victimization cases as "emergencies" which allow for immediate entry of the client into public housing, workers should consider discussing this possibility with their local housing authority and should do so before an actual case arises. Public housing might become an available resource.

If it appears that the client and the abuser need to be separated because of abuse, as opposed to neglect, the worker should encourage the client to file a petition to require the abuser to vacate the current home. This will require the abuser and not the elderly victim to make the physical move. This can normally be done if the victim owns the home or pays the rent on the housing, but is less likely if the abuser owns the home or pays the rent.

If there is no alternative available which will allow the client to remain in the home, the worker should assist the client in finding permanent alternative housing. If the current living situation is dangerous to the client, it may require the worker to seek short-term and long-term housing options at the same time.

The difficulty of finding alternative housing and the poor health of many victimized elders frequently lead workers to the conclusion that hospitals or nursing homes are the best placements for their clients. Before recommending such a placement to the client, the worker should be certain that this move is in the best interests of the client.

Before any alternative housing move is made, the worker and client should complete the financial and supportive service planning assessment discussed above to assure that the client has his/her financial well-being protected and that the necessary support services will be available as soon as the move is made. Even when the client is the person who moves, it may be wise to obtain a restraining order against an abuser if retaliation or continued abuse appear likely.

Since some clients may be on medication or under regular medical care, the worker and client should be certain that any physical move does not interfere with such treatment. The client's nurse or physician should be consulted about the possible effects of such a move and appropriate protective measures taken.

All of the measures described above need to be accompanied by a close and caring relationship between the worker and client. Weeks or months may pass before a successful resolution is achieved.

CASE PROTOCOL #2

Type of Client: Competent, non-consenting client.

Characteristics of Client:

- The person is an alleged or actual victim of abuse, neglect, exploitation, or abandonment (these four hereafter referred to as victimization).
- The person is legally competent and has not been adjudged incompetent by a court of law and therefore has not had a full guardian appointed to oversee his/her life or assets. Nor has the client been committed to an institution by a court of law.
- The person understands what has happened to him/her and does not at present desire to take action to halt further victimization, and may not be prepared to admit that victimization has occurred.

Outline of Case Plan

Initial Case Contact: A worker in a community agency receives a report of or uncovers a case of suspected abuse, neglect, exploitation, or abandonment. This report will in all likelihood be from a third party and not from the client/victim. At this point, the worker may or may not have an indication that the client does not desire to take action to halt further victimization.

Initial Case Assessment: The worker contacts the victim/client to discuss the problem, verify the reported victimization, gather further information, and discuss methods for resolving the problem.

If the worker suspects that the client is not prepared to admit victimization and/or to take action to halt further incidents, the worker should be conscious that this initial contact may either open a dialogue with the client or end it. If the worker does not know how receptive the client will be to this initial contact, then the worker should proceed on the assumption that the client, will, at minimum, be hesitant to take action.

The worker should try to establish rapport with the client while gathering information utilizing non-directive questions. The worker should not press the matter if the client appears hesitant to give information about the alleged victimization. The goals of the initial case assessment are:

- To open a dialogue.
- To gather information and attempt to verify whether victimization exists.
- To learn whether the client desires assistance to prevent further victimization.
- To determine if other supportive services are needed.

The client has the right to reject any unwanted intrusions into his or her life. This initial case assessment visit may be considered such an intrusion. The worker should use all of his/her skills to make the client feel that this is a positive interaction. If the client refuses to have anything to do with the worker and expresses a desire to be left alone, the worker must respect this right to privacy. The worker should receive a clear indication from the client that s/he wishes to proceed with the case before proceeding further him/herself.

It is the client's right to refuse any assistance of any kind, including further visits from the worker. The worker should accept the client's decision and terminate the relationship.

To be certain that the client definitely does not wish to have any further contact, the worker should ask the client whether s/he is sure that s/he does not want any of the services which are available. This should be done by describing each service individually.

The worker should record these events fully in the client file for future reference and for his/her own self-protection.

The relationship between the client and worker should continue if the client refuses to either admit that victimization has occurred or desires to take no action to prevent further incidents, but does desire either continued contact with the worker or other supportive services. With many competent, non-consenting victims, this contact may be the most to be achieved at the conclusion of the initial assessment.

The client has a right to privacy and confidentiality concerning anything discussed with the worker. Before proceeding with further investigations and interviews with other parties, the worker should request and receive permission to do so from the client (in writing, if possible).

Case Evaluation and Case Plan Development: General Considerations

The worker and his/her supervisor should begin the process of conducting a case evaluation and developing a case plan if the worker is reasonably certain that the client has in fact been victimized and the client has not terminated the worker/client relationship. The client will control this process.

The worker and his/her supervisor should determine whether the worker will continue to be the primary worker or whether it should be transferred to a protective service worker or someone else with more time to devote. If it is decided that the worker will change, the worker should discuss this with the client and clearly indicate that another person will be contacting the client in the near future on this matter. This transfer of worker responsibility is critical and should be handled with great sensitivity to the client's needs. The initial worker should accompany the new worker on his/her first visit to the client and should thoroughly brief the new worker on the facts of the case.

The case evaluation will have to proceed slowly, possibly extending over weeks or months. It should be controlled by the client's willingness to allow it to proceed. Until the client agrees to allow the worker to discuss the case with other persons, the worker has a responsibility to protect the client's privacy by not contacting others (family, friends, other service workers, etc.) to learn more about the client.

With a competent, non-consenting client, the case plan should be:

- To carry out the client's wishes for further contact and services, to the extent that those desires are possible and appropriate.
- To build a trusting relationship with the client which will result in the client's calling upon the worker for assistance with the victimization or with other problems.

The worker should continue to piece together the true facts of the case and provide such support as the client needs and wants.

While the client may never admit that victimization is occurring, s/he may agree to accept assistance which will alleviate some of the causes of the problem.

To the extent that the client agrees to accept assistance for other problems, s/he will also be broadening the access the worker has to other workers who have had contact with the client. With the client's permission, the worker may discuss the case with these other workers.

When the worker has developed a fairly complete profile of the client and his/her problems, s/he may present the facts of the case to a local protective services committee, a physician, nurse, mental health worker, lawyer, or other protective services worker. The client's identity should be concealed, but sufficient facts should be presented to allow for a discussion of the case. In this way, the worker may elicit ideas on how best to proceed with the case without violating the client's right to privacy.

As soon as the worker has a fairly complete set of facts concerning the case, the worker should develop a case plan consisting of a number of alternative courses of action which focus on providing support services and/or protection of the client and his/her property. The case plan should have as its goal the prevention of further victimization even if the client never admits that it exists.

Case Evaluation and Case Plan Development: Specific Considerations

In conducting the case evaluation and developing case plans for a competent, non-consenting client, the procedures described in the protocol for the competent, consenting client may be followed (and therefore will not be repeated in this protocol), with the following differences:

Existence of Victimization

The instance(s) of victimization will have to be discovered and verified without the client admitting its existence in most cases. Therefore, the worker will frequently need to use indirect questioning to obtain this information. Frequently, the worker will need to intuit what the problem is, which means that the worker needs to be very careful not to jump to the wrong conclusions.

Competency of the Individual

If the client does not have a guardian or has not been legally committed to an institution and clearly can function in his/her daily life without threat to him/herself, then the client is almost certainly competent. Therefore, use of guardianship or commitment procedures need not be considered by the worker as possible remedies.

Use of an Abuse Prevention or Domestic Violence Act

In the case of a competent, non-consenting client/victim of abuse, the use of an Abuse Prevention or Domestic Violence Act (if the state

has one) will not be possible as the victim is the only one who can file a petition with the court under such an Act. Until the client admits that the abuse is occurring and agrees to take action under the Act, this remedy will not be available. At a later date the worker may want to again raise the possibility of using the Act.

Financial, Housing, and/or Support Services Issues

Basically, the same alternatives available to the worker who has a competent, consenting client are available for a competent, non-consenting client. The difference is that the client will probably not admit that the victimization is actually occurring, but may admit that certain specific actions "might help" him/her function more effectively - e.g., changing the representative payee for the Social Security check might help him/her have easier access to funds; having a homemaker or transportation to the doctor might help the family care for the client; or getting out to a Senior Center or to a meals site might be enjoyable.

The main goal of cases involving competent, non-consenting clients who appear to be victims of abuse, neglect, exploitation, or abandonment is to prevent further victimization by providing support which they will allow. If cessation of abuse or neglect can be achieved without the client admitting that there is such a problem, so be it. Certainly acknowledgement of the problem helps the worker, but such an acknowledgement is not crucial to successful resolution of the case.

CASE PROTOCOL #3

Type of Client: Emergency case client.

Characteristics of Client:

- The person is the actual victim of abuse, neglect, exploitation or abandonment. (These four are hereafter generally referred to as victimization).
- The result(s) of the victimization place the person in immediate danger of irreparable harm to self and/or property.
- The person may or may not be legally competent, may or may not have been judged incompetent by a court of law, and therefore may or may not have had a full guardian appointed to oversee his/her live or assets. The client is not currently committed to an institution by a court of law.
- The person may or may not understand what has happened to him/her and may or may not desire to take action to treat the results of the victimization.

Outline of Case Plan

Initial Case Contact: A worker in a community agency receives a report of or uncovers a case of suspected abuse, neglect, exploitation or abandonment which places the person in immediate danger of irreparable harm to self and/or property. This encounter with the person may be the result of a chance meeting or a report from someone else.

Initial Case Assessment, Evaluation and Case Plan Development: Unlike other cases of elder victimization, emergency cases are unique in that the assessment, evaluation, case plan development and implementation must be done in a very short period of time - sometimes hours or maybe one or two days. As a result, the effectiveness of the assessment, evaluation and case planning take on heightened importance.

The client has the right to reject any unwanted intrusions into his or her life. This initial case assessment visit may be considered such and intrusion.

This right is inherent and my be infringed upon only if the person has been judged incompetent by a court of law or if the public health and safety demands or allows this infringement. The worker should use all of his or her persuasive powers to get the client/victim to agree to act in such a way as to protect him/herself from further harm.

Typical emergency cases involve clients who are or appear to be in severe need of medical attention due to neglect or abuse. Sometimes the emergency is not a health emergency, but instead is a financial emergency in which the victim is being exploited by another party and is in imminent danger of losing all or a substantial part of his/her funds or property. In any of these cases, the client may be competent, incompetent or apparently so, unconscious or semi-conscious.

Clients in a Medical or Financial Emergency

In cases in which the client is or appears to be in a medical or health emergency, the worker often encounters a client who has been severely physically abused or has been the victim of severe neglect either imposed by others or self-inflicted. In cases of financial emergency, the worker may encounter a client who is in the process of being severely exploited by some person or is mismanaging his/her finances.

The worker's first encounter with this type of client will normally be either through a referral from another worker or through a home visit to one of the worker's own clients. In these cases, access to the client is usually no great problem since the worker either already has a good relationship with the client or can gain access by being accompanied by the worker or person making the referral.

If, however, the worker gets a report from someone who will not accompany the worker or does not know the client personally, then access may be a problem.

If the client is unconcious, access is certainly a problem, but normally the police can be prevailed upon to let a worker into the person's home.

If the client is unconscious, access is certainly a problem, but nor- to take any action. If this consent is not received, the worker may not proceed without additional police or court-granted authority.

The worker should be especially careful not to over-react to cases of suspected victimization. The mere fact that the person is living in sordid conditions does not mean that an emergency exists. The worker needs to assess whether the situation is actually life-threatening or will cause irreparable harm to the person. Most of the information the worker will receive will come directly from the client. If the client is in a severe health condition, the worker should ask the client the name of his/her physician or health facility for a quick consultation.

Possible Legal Remedies

Abuse Prevention or Domestic Violence Acts

If the victim is competent but non-consenting, the civil remedies will not be available to halt further abuse. If the client consents, statutes in some states allow the courts to act within hours to order the abuser to halt the abuse and possibly to vacate. The client must simply demonstrate that the abusive situation is immediate and dangerous to his/her safety. Orders issued in this emergency situation are normally valid until the end of the next regualr court working day, at which time additional protective orders must be sought.

Some states require the police to use all reasonable means to prevent further abuse if there is reason to believe that a family or household member has been abused and if the abuse is imminent and seeking a court order would take too long. This may include:

- Staying on the scene as long as there is danger to the physical safety of the person.
- Assisting the person in obtaining medical treatment, including driving the person to the emergency room of the nearest hospital.
- Giving the client immediate notice of his/her rights.
- Arresting the abuser if there is probable cause to believe a felony has been committed, or if a misdeameanor has been committed in the officer's presence. Informing the abused person that s/he can file criminal complaints for threats, assault and battery, etc.

Once the abused person has obtained a protective order from the court, any violation of the order is a crime. Violation of the order makes the violator subject to immediate arrest if the police has probable cause to believe that the order has been violated.

Temporary Guardianship or Conservatorship

If the client appears to be incompetent and is in an emergency situation, such as acute illness, a petition for a temporary guardianship or conservatorship may be filed. An attorney is usually needed to file the petition. Depending upon the facts of the case, the court may reduce or eliminate notice requirments to the proposed ward and his/her nearest relatives. The case may be heard and decided within a matter of hours or days, depending upon the emergency.

Because this remedy is so great an invasion of the person's rights and because notice requirements may have been severely reduced, the court will require strong evidence of the person's incompetence and the emergency nature of the case.

If the temporary guardianship or conservatorship is granted, it is time-limited and usually renewable only once. The guardianship or conservatorship may be either broad or limited to only certain types of decisions and actions. Normally, the courts grant broad orders, unless specifically requested to grant limited orders.

Emergency Commitment

The most restrictive remedy for any case, emergency or not, is civil commitment. It should be resorted to only in extreme cases. Civil Commitment is the process by which a court orders a person to be involuntarily confined for treatment in a mental hospital.

Civil commitment may be ordered only if strict criteria are met such as:

- The person is mentally ill, i.e., has a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgement, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life;
- The person is shown to be dangerous to a degree that failure to confine would create a likelihood of serious harm to self or others; and
- Commitment is the least restrictive alternative.

A person may be committed involuntarily for a short period (usually a matter of days) upon application to a mental hospital by certain persons, such as:

- A physician designated by the facility;
- A police officer acting in an emergency where no designated physician is available;
- A trial court judge, after notice and hearing.

Specifics of emergency civil commitment vary from state to state.

If application is made by a physician or police officer, the person may be held during this time period without judicial intervention. However, the person must be given an immediate psychiatric examination,

if none was undertaken prior to admission, and must be advised of his/her right to be admitted voluntarily. Additionally, a determination must be made at admission that confinement is the least restrictive alternative.

What happens after the temporary confinement? The person must be released unless the superintendent of the facility, or other authorrized person, petitions the court for an extended involuntary commitment prior to the expiration of the temporary period. The person may remain hospitalized on a voluntary basis. Once the petition is filed, the person can be detained until a court hearing and the case is decided. Thus, an individual hospitalized on an emergency basis may be confined beyond the initial temporary period, often for several weeks or more, by the filing of a petition.

After the petition is filed, the court must notify the person and legal guardian of the Court's receipt of the petition and of the date on which the hearing on the petition will be held. Unless the hearing is waived in writing, the Court must then notify the person, his/her lawyer and nearest relative or guardian of the time and place of the hearing.

As noted earlier, the person has the right to be represented by counsel and to have counsel appointed if s/he cannot afford to hire a lawyer. At the hearing, the lawyer may call witnesses on behalf of the patient, cross-examine the hospital's witnesses (including the psychiatrist), and demand production of medical records and other documents. The patient also has the right to an independent psychiatric examination. If the judge finds that criteria for commitment are met and that the facility offers the least restrictive alternative for treatment, continued confinement will be ordered.

Financial, Housing and/or Support Service Issues

The same actions available to the worker who has a competent, consenting client are available in emergency cases. (See competent, consenting client protocol for detailed description of activities the worker should consider and/or undertake). However, the worker must conduct many of these activities under severe time constraints.

It is in emergency cases that the value of protocols, pre-planned community responses, local protective services committees and formal and informal interagency connections pay the greatest dividends.

Privacy and confidentiality have a way of being violated in cases of perceived emergencies. The worker should, if possible, obtain the client's consent to talk about the case with other persons as necessary to prevent further harm to the client. If the consent cannot be obtained because of the client's incapacity, the worker should discuss the case with others only to the extent absolutely necessary to meet the client's needs.

If the client refuses to allow the worker to discuss the case with others, the worker should proceed only if s/he is certain that the client would suffer irreparable harm due to the emergency nature of the situation.

In emergency cases, there is likely to be a need for extensive support services, financial aid, and housing assistance. The worker may have to devote many hours to these tasks in a short period of time.

The client in most situations has a right to refuse assistance. These refusals should be documented in the case record with the date, time, and worker's signature.

CASE PROTOCOL #4

Type of Client: Incompetent client.

Characteristics of Client:

- The person is an alleged or actual victim of abuse, neglect, exploitation, or abandonment (generally referred to as victimization).
- The person is legally incompetent, which means:
  - S/he has been judged incompetent by a court of law and/or has a full guardian appointed to oversee his/her life and/or assets;
  - Or the person has been committed to an institution by a court of law;
  - Or the person has a severely limited understanding of what has happened to him/her and may or may not admit to victimization or care to take action to halt further episodes.

Outline of Case Plan

Initial Case Contact: A worker in a community agency receives a report of or uncovers a case of suspected victimization. At this point, the worker may or may not have an indication that the client is incompetent.

Initial Case Management: The worker contacts the victim/client to discuss the problem, verify the reported victimization, gather further information, and discuss methods for resolving the problem.

If the worker knows that the victim/client has a guardian or conservator, that should not deter or prevent the worker from meeting with the client. The worker should be especially attentive to the client's ability to understand information which is provided and the ability to make basic decisions. The worker should remember that the client has only very limited authority to make his/her own decisions about tasks of daily living. The worker should use this visit to try to gather information about the client's problem, not necessarily to make decisions with the client about tasks to be undertaken in the future.

If the worker does not already know that the client is incompetent or might be judged so by a court of law, this possibility will probably become apparent to the worker as the interview progresses. The worker should attempt to discern whether the client has real problems understanding the basic facts and concepts, and whether the client can care for his/her basic needs or recognize and cope with potentially harmful situations.

The primary purpose of this visit should be to gather information about the client's perceived needs and his/her situation; secondly, to begin to evaluate the client's competency; and thirdly, to determine what further assistance is needed.

After the visit to the client, the worker should record in the case file his/her observations concerning the client's needs, living situation, ability to understand basic facts, make basic decisions, and provide for basic needs. This is important so comparisons can be made in the future concerning the client's abilities to function at different times. The case record over a period of time should show whether the client is more lucid and capable at one time than another.

The client has the right to reject any unwanted intrusions into his or her life. The initial assessment visit may be considered such an intrusion. The worker should use all of his/her skills to make the client feel that this is a positive interaction. If the client refuses to have anything to do with the worker and expresses a desire to be left alone, the worker must respect this right to privacy. The worker should receive a clear indication from the client that he/she wishes to proceed with the case before proceeding.

If the client clearly states that s/he does not need or want assistance including further visits from the worker, that is the client's right. The worker should terminate the relationship. If the worker believes the client is incompetent and without a guardian then s/he should discuss this with the agency supervisor to determine whether the agency on its own behalf, or through family or friends of the client, should pursue the appointment of a guardian or conservator for the client.

The worker should ask the client whether s/he is sure that s/he does not want any of the available services. This should be done by describing each service individually.

The worker should record these events precisely in the client file for future reference and for self-protection.

If the client refuses to either admit that victimization has occurred or desires to take no action to prevent further episodes, <u>but</u> does

desire continued contact with the worker or other supportive services, the relationship between the client and worker should continue. Continuing contact may be the most that can be achieved at the conclusion of the initial case assessment.

If the worker knows that the client has a guardian or conservator and the client agrees to some further contact, the worker should ask the client for permission to talk with the guardian or conservator if that appears necessary. If the client says no, the worker should accept that. However, if the worker feels very strongly that such a contact is necessary, s/he might tell the client that s/he will only proceed with the case if allowed to talk with the guardian or conservator. If the client says no, the worker has the choice of withdrawing from the case.

The client has a right to privacy and confidentiality concerning anything discussed with the worker. Before proceeding with further investigations and interviews with others, the worker should request and receive permission to do so from the client (in writing, if possible).

Case Evaluation and Case Plan Development: General Considerations

If the worker is certain or reasonably certain that the client has been victimized and that client wants to continue the worker/client relationship, the worker and his/her supervisor should conduct a case evaluation and develop a case plan.

The worker and the supervisor should determine whether the worker will continue to be the primary worker on the case or whether it should be transferred to a protective service worker or to someone else with more time. If it is decided that the worker will not be the primary worker on this case, then the worker should discuss this with the client and clearly indicate that another person will be contacting the client in the near future. The transfer of worker responsibility is critical and should be handled with great sensitivity to the client's needs. The initial worker should brief the new worker on the facts of the case and accompany him/her on the first visit.

In cases involving incompetent or apparently incompetent clients, there are three client types:

- A client who indicates that his/her guardian or conservator is the victimizer.
- A client who believes that his/her guardian or conservator is the victimizer.
- A client who appears to be incompetent but has not yet been legally judged incompetent.

The three types of cases will need different treatment. In the first two cases, the client already has a guardian or conservator. The primary role of the worker will be to work closely with the client to attempt to determine if the guardian or conservator is in fact victimizing the client or otherwise neglecting his/her duties. If so, the worker should attempt to have the surrogate removed by the court and have someone else appointed, if that is still necessary. If the alleged neglect of duties is not verified, the worker should attempt to make this clear to the client and ask permission to discuss the matter with the guardian or conservator.

In cases in which the client/victim apparently is incompetent but has no guardian or conservator, the primary role of the worker will be to work with the client to attempt to create a situation in which the problem is alleviated, and the client receives the least restrictive protective care required. This may require that a petition be filed to appoint a guardian or conservator for the client.

In cases involving incompetent or apparently incompetent clients, the worker should seek the advice of an attorney and a local protective services committee. These cases involve legal, medical, and mental health issues, and usually require interagency cooperation.

The central issue in cases involving an incompetent client without a guardian or conservator is the client's ability to give consent. The worker may reach a point where s/he must decide whether the client has the ability to consent. If the worker decides the client lacks this capacity, the worker must decide whether and how to proceed.

If the decision is to proceed, the worker should seek to have a guardian or conservator appointed. At this point; the worker no longer represents the client's interests, necessarily, and should therefore help the client obtain a lawyer to represent his/her interests at the court hearing.

The worker has a responsibility to protect the client's privacy. Once the worker moves for a guardianship, conservatorship, or civil commitment, there is still a responsibility to maintain the client's privacy and to reveal only the facts concerning the client as are necessary and legally permissable for the limited objective(s) being sought.

Case Evaluation and Case Plan Development: Specific Considerations

In conducting the case evaluation and developing case plans for an incompetent client, the procedures described in the protocol for the competent, consenting client may be followed to a great extent (and therefore will not be repeated in this protocol), with the following difference:

Existence of Victimization

The incidence of victimization must be discovered and verified with the permission of a client who may lack mental competence and may have limited periods of coherence. The worker may be hesitant to accept the assertions of the client concerning the alleged victimization. In some cases this will make the verification process difficult.

The worker should seek the consent of the client to discuss the case with other persons who may have information regarding verification. The worker should use every means available to enable the client to understand what s/he is being asked to consent to and the consequences of giving this consent. Once the consent is or is not given, the worker should carefully describe in the case file what the client was told and the client's response.

Use of an Abuse Prevention or Domestic Violence Act and Other Legal Remedies in Cases of Elder Abuse

Usually only the victim of abuse can file a petition with a court under an Abuse Prevention or Domestic Violence Act. There remains a major issue of whether a court will consider the petition of a person who has already been judged incompetent or who quite clearly does not understand basic facts and the implications of his/her decisions. At this point the client should be represented by legal counsel.

If the client has a non-abusive guardian or conservator, then s/he should probably be the petitioner on behalf of the client. If the current guardian or conservator is the abuser, then a petition should be filed to remove the guardian or conservator. It may or may not be necessary to also file a petition under the Abuse Prevention or Domestic Violence Act. In the latter situation, there must be strong evidence to support the removal of the guardianship, and the court will probably require more than the client/ward's word.

The worker should discuss with his/her supervisor whether the agency should petition for the removal of the guardian or conservator if the current guardian or conservator is the abuser and the client/ward does not consent to the removal of the guardian or conservator, or simply does not comprehend the worker's explanation of what this means or will do. Generally, anyone may petition for the removal of the guardian or conservator. At the same time, a petition for a temporary restraining order against the abuser might be sought to protect the client.

When Neglect or Exploitation Exists

If abuse has not occurred but either neglect or exploitation exist, and the client has a guardian or conservator or is in need of one, then the following actions might be taken.

If the client has a guardian or conservator and the worker verifies that s/he is the person responsible for the neglect or exploitation, then the worker should informally approach the person and suggest that s/he improve his or her performance. If that should fail, the worker should be prepared to have a petition filed for removal of the person as guardian or conservator, or to arrange for a lawsuit against the guardian or conservator for breach of duty.

If it appears that harm might be inflicted upon the client as a result of these petitions, they might be filed as emergency petitions along with a request for such restraining order or injunction as necessary to prevent harm.

The worker, client, and legal counsel should work together to petition for a guardian or conservator if the neglected or exploited client does not have a guardian or conservator but appears to meet the standards required for creating a guardianship or conservatorship and this would be the least restrictive alternative.

Seeking a guardianship or conservatorship infringes on the client's liberty. Before seeking either remedy, the worker should develop a number of case plans for resolving the client's problems. Various remedies which are less restrictive but may provide a means for alleviating the neglect or exploitation include the following:

- Representative payee
- Trusts
- Direct bank deposits
- Joint bank accounts
- Powers of attorney

Each of these remedies has limitations and/or drawbacks and therefore each should be discussed with an attorney before recommendation to the client. If the client is clearly incompetent, these remedies will not be appropriate.

Financial, Housing and/or Support Services Issues

The same actions that are available to the worker for a competent, consenting client are available for an incompetent client. The difference is that if the client is incompetent, the case planning will need to be done in conjunction with the guardian or conservator. If the guardian or conservator is the source of the problem(s), then the worker may have to ask him/her to improve performance or seek his/her replacement. The worker will then need to develop and implement the case plan in conjunction with the new guardian or conservator.

A responsible guardian or conservator may be all that is needed to protect the client from further victimization. But it may also be necessary to locate alternative housing or provide other support services. In these cases, the goal is to assure that the client has a responsible surrogate and that, through that surrogate's help, the client receives necessary services.

PART III:

DEVELOPING STATE AND COMMUNITY RESPONSE SYSTEMS

CHAPTER 7

PROTECTIVE SERVICES SYSTEMS

Elderly abuse is rooted in a diversity of factors, including the expectations of family members in caring for elderly parents, family relationships, and the external and internal stresses on the family. There is no simple answer as to why abuse occurs. There is, likewise, no simple solution. The complexity of the problem demands a comprehensive approach to its solution.

It is necessary to organize the full range of identification, assessment, treatment, and prevention services available to victims and their families. Without such organization, critical gaps and lags occur in service provision, sometimes with disastrous results. Emergency cases in particular require a prompt and comprehensive response.

Current research indicates that well-organized protective service systems generally do not exist to cope with the problem of elder abuse. In most communities, a wide variety of health, social, and legal services are available to assist elders who are in need, but they have not been molded into a single, cohesive delivery system for abuse victims.

This chapter discusses what is needed to create such a protective service system in a community or state.

The model consists of:

- General systems characteristics which any community should keep in mind when setting up an adult protective services system serving abused and neglected elders.
- A listing of core services which are essential to any such protective services system.
- A listing of additional (and important) support services which are largely unavailable in most communities.
- A delineation of those tasks which could be most efficiently undertaken on a statewide - as opposed to community - level.

General Systems Characteristics

Any effective protective services system must have two essential ingredients:

- Pre-planned individual case responses or protocols which enable the system (and its individual workers) to respond quickly and properly to the type of case being confronted.
- The capacity for a coordinated, interdisciplinary response on the part of the service system to both emergency and chronic situations.

Interdisciplinary Response

Abuse is a multi-dimensional problem that requires assistance from many service agencies. Services which are available in a given community must be coordinated for individual cases. An efficient means of developing this coordinated response is the formation of a formal protective services committee composed of representatives of agencies who agree to provide services to abused elders.

The inter-agency committee's role is two-fold:

- To establish linkages between agencies that will lead to protocol development and the timely coordinated delivery of services.
- To provide an on-going review mechanism for individual cases.

Core Services in a Protective Services System

While the services required by individual clients will differ, a protective services network for abused elders should be able to provide a basic group of core services, many of which are currently available in most communities.

These core services can be provided through one umbrella agency or through formal agreements between providers. The formal agreements can be contracts to purchase services, but need not involve a transfer of dollars. Instead of exchanging dollars for services, a *quid pro quo* arrangement can be made through which units of one service are matched or exchanged for units of another service.

The Protective Services Worker

Because of the many disciplines and services which must be brought together in an abuse case, it is essential that one person be held accountable for managing a given case. This person, the protective services worker, plays a crucial role in linking community resources to the victim and his/her family and in assuring the system's response to change in the victim's environment. The protective services worker should also be the means for linking the victim's family and, if possible, the abuser to supportive and counseling services.

A protective services worker may be a worker who handles only abuse, neglect, exploitation, or abandonment cases or a worker who handles a range of cases. Opinions differ as to which approach is best. Often, available funding is the determining factor. Whichever the approach, to be effective the protective services worker must have:

- A flexible case load.
- Authorization and ability, at any time, to devote 5 to 40 hours a week to one case if necessary.
- Authorization and ability to assist workers in other community agencies on their cases so that informal, mutually supportive arrangements can be developed.
- A supportive and knowledgeable supervisor.
- Adequate training prior to handling abuse cases.
- A knowledge of virtually all financial, housing, health, mental health, legal, religious, and social services in the community.

Designating specific persons as protective services workers for abuse victims is an important means of assuring the system's accountability to the client. Recent literature also shows the importance of a stable and on-going client-worker relationship in successfully dealing with abusive situations.

A Case Assessment Team

Once a suspected case of abuse is reported, the system must be able to evaluate the need for services and provide the most appropriate response. In the most complete system, this assessment would be made by a team composed of:

- A physician with geriatric experience (or a nurse clinician under the direct supervision of a doctor).
- A trained human services professional with gerontological and casework experience.
- A lawyer.
- A psychiatric case worker.

Not every case of suspected abuse will require a complete evaluation by every member of the team. In some communities, resources might not be available to have such a team meet regularly. In such instances, a trained worker could perform an initial assessment, using certain pre-determined protocols for calling in other experts to assure access to a full range of assessment skills.

The assessment team or assessment worker will need to work closely with legal counsel. The role of the counsel at this point is to assist the assessment team or worker with a legal evaluation of the case and to provide legal advice as to the proper steps to be taken by the team or worker in the case.

Primary Health Care Services

These services may be delivered at home or on an inpatient or outpatient basis. They include:

- Nursing care.
- Physician services.
- Hospitalization.
- Mental health services.
- Emergency Room services.
- Ambulance service.

Legal Services

Legal services needed in elder abuse cases are of two distinct types: services for clients and services for workers. In cases of mentally competent clients in which the client and worker agree on the case plan, the same lawyer may serve both the client and and the worker. However, when the client and worker disagree on the case plan or when the client is mentally incompetent and the worker wants to petition for a guardian, conservator, or civil commitment, separate legal counsel should be available to the client and the worker.

Legal services for the client may include:

- Advice and possible representation in criminal or civil actions against the abuser.
- Advice on potential eviction, utility shut-off, SSI or Medicaid termination, health care or social service denial, and similar matters.
- Advice and possible representation in a guardianship, conservatorship, or civil commitment proceeding.
- Advice and possible representation in a right to treatment or a right to refuse treatment situation.

In cases where guardianship or other means which would restrict the client's rights are being contemplated by the protective services worker, legal counsel for the client should be arranged as soon as such action is considered. At that point, the system and the individual are in an adversary position, and the client should have legal counsel to protect his/her rights.

Legal services for the client may be obtained from local legal services offices, legal programs for the elderly funded by Area Agencies on Aging under the Older Americans Act, bar association referral programs, and private attorneys.

Legal counsel for workers is frequently non-existent. Agencies often view it as an expensive frill. Yet it is essential in many elder abuse cases. Specifically, workers may need advice on matters such as:

- Worker liability for possible slander, alienation of affection, invasion of privacy, or trespass.
- Right to information under the Freedom of Information laws.
- Issues involving responsibilities to act or not act in certain circumstances - e.g., to report or not to report a crime committed by the client's family against the client.
- Standards for imposing a guardianship or conservatorship.

Finally, in some cases, the worker and agency may need legal representation to petition for a guardianship, conservatorship, or civil commitment.

Providing legal counsel for both clients and workers is essential in protective services cases. It helps assure that workers can best serve their clients and that clients' rights are protected.

Legal counsel should also be utilized for staff and community training and education sessions on protective services issues.

Homemaker/Home Health Aide Services

Public and private homemaker/home health aide agencies in most communities provide housekeeping services, meals preparation, shopping assistance, and other similar services.

Transportation

These services may be available through social and health service agencies, Area Agencies on Aging, religious groups, private charitable organizations, and public and private transportation systems. Friends and neighbors may also be helpful in providing this service.

Nutrition

These services include meals-on-wheels, congregate meals, shopping, and cooking services, and are available through local Older Americans Act nutrition programs, church groups, and other private charitable organizations.

Financial Assistance

In some case of elder abuse, the victim may be dependent upon the abuser for support. It is important therefore for the protective services system to have either some cash on hand or other means for assisting the client through an immediate financial crisis. The protective services system must also be able to handle long-term financial needs. This means the protective services workers must have a working knowledge of all income and other public benefit programs.

Police Services

Police should be contacted when the client is in imminent danger of bodily harm in order to assure the worker access to the premises and, if necessary, to assist in removing the client from harm. Police can also arrange ambulance services.

Under some state Domestic Violence statutes, police play an important role in protecting the victim from continuing harm, enforcing restraining or vacate orders, and arranging services for the victim.

A role for which police presence is not appropriate is to assure access where imminent danger to the client is not a factor. Inappropriate use of the police by the protective services worker may create hostilities in the victim and family which will be difficult to overcome.

Emergency Services

The protective services system must be able to provide immediate services to diminish or prevent the threat of grievous bodily harm or death to a client. This emergency capacity should include a 24-hours-a-day, seven-days-a-week response capacity and the following services:

- Emergency housing (at least two nights duration).
- Emergency medical care (in the home or by ambulance to service site).
- Emergency funds.
- Legal services (for advice to or representation of the client).

Emergency services should not be limited to crisis intervention. Clients receiving emergency services should be mainstreamed into the client pool as soon as the emergency has been resolved. Reliance on crisis intervention alone results at times in inappropriate case diagnosis or repetitive abuse.

Follow-up

All cases, regardless of disposition, should be reviewed on a regular basis. An initial review might be conducted by the protective services committee within thirty days of the opening of a case and each ninety days thereafter.

Supplements to Core Services

Most of the core services listed above, while not evenly distributed or adequately funded in all or even many geographic areas, do exist throughout most states. The major gaps in core services are normally the lack of protective services workers, case management teams, and legal counsel for workers. The main need is to organize the services into protective services systems and to assure their availability to victims of abuse.

Other important services listed below are often unavailable, however, and unavailability seriously weakens the system's capability to deal with cases of elder abuse. While individual communities may be able to establish these services for their client, a national or state-wide effort is needed to assure their availability in all areas.

Emergency Shelter/Housing

This need constitutes perhaps the single greatest gap in services to victims of elder abuse. Workers are frequently forced to rely on hospital and nursing home beds for placement of abuse victims. Experience indicates that the lack of emergency housing often results in temporary hospitalization followed by inappropriate placement in a nursing home.

In some instances, removal of the victim from the abusive situation is the only way in which s/he can be protected. While hospitals and nursing homes may be suitable placements for certain individuals, alternative, short-term options are needed for many others.

State or federally funded projects are required in this service area. Until such programs are established, existing community facilities should be coordinated to help provide emergency housing. Convents, dormitories on college campuses, guest houses, and public housing should be considered. Often special facilities and services must be added to accommodate the needs of frail or handicapped elders.

Counseling Groups for Victims and Abusers

As indicated, one of the most difficult problems in dealing with cases of elder abuse is the unwillingness of the victim to talk about it. For various reasons, many battered elders refuse to confront the fact of their victimization. Individualized counseling for abuse victims is often needed throughout the investigation, assessment, and service delivery phases of the case.

Group counseling may also be an effective means for helping the elder cope with victimization. Models for this type of service are provided by existing self-help groups such as organizations serving rape victims.

Thought should be given to the formation of self-help groups for abusers. Parents Anonymous, an organization of parents who have abused their children, provides a successful model in this area.

Foster Care for Elders

Foster care for elders is a new service concept being piloted in a small number of areas in the country. This and other long-range placement options (such as congregate housing) are necessary for victims of abuse who can no longer live alone or who must be removed from their family's care.

Day Care or Recreation/Activity Centers for Elders

Respite care for elders (both on a regular daytime basis and for weekends or longer periods of time) gives families a break from their sometimes overwhelming responsibilities. Respite care may serve both as a safety valve in preventing abuse and as a half-way step, once abuse has occurred, which permits families to readjust gradually to caring for the elder.

In instances where the abused elder has led an isolated existence, day care and recreation programs can help provide a necessary social and support structure.

Statewide or Uniform Service System Characteristics

The model protective services approach described in this chapter does not assume the passage of a statute mandating elder abuse reporting or the designation of a single state agency responsible for handling abuse cases. While these are important, and should be actively encouraged, it is possible for communities to begin framing their own responses to elder abuse within existing legal and administrative structures.

Standard Record Keeping

The protective services system can be improved by standardized record keeping which permits audits for service and client characteristics. Records should reflect service goals as well as casework process and should be kept by client number so that confidentiality can be maintained during case reviews.

Uniform record keeping creates both data for planning purposes and a case review capacity which promotes timely handling of cases, systematic reviews of individual client progress, and adequate fair hearing and grievance procedures for clients and their families. An annual report based upon this information should be prepared by a designated state agency.

Uniform Eligibility Guidelines

Adult protective services are usually funded under Title XX of the Social Security Act. They must be provided without regard to income. The question of whether to include disabled persons over eighteen years of age in any statute which mandates adult protective services, or to confine legislation to the sixty-plus population is obviously an important one, since this decision will have an impact on the design of the services delivery system and the cost of the program.

Uniform System of Case-Finding, Reporting, and Referral

While it is not essential that a single agency be designated in each area for receiving reports of elder abuse, or that the agency be identical across all areas of the state, it is important that this responsibility be clearly pinpointed in each service area. A network of agencies, such as visiting nurse associations or hospitals, could be designated to perform this function and to be responsible for subsequent referral to other community organizations. Social service or family service agencies could also be designated.

Regardless of which agency/agencies are designated in each area or community, it should:

- Receive abuse reports.
- Assign an assessment worker or a team to investigate each report.
- Refer the case to a protective services team or worker for case planning and services delivery.

This agency should receive regular status reports on all referred cases.

Confidentiality Guidelines

A great deal of uncertainty and confusion exists around issues of confidentiality as they relate to elder abuse cases. Because of the need for coordinated service responses, it is necessary to share client information across a number of agencies when dealing with cases of elder abuse. In instances where abuse is merely suspected, assessment of the problem may often involve client evaluations by more than one profession. Standardized client release forms and procedures for protecting client information would be useful. Such uniformity would help assure that the client's right to confidential treatment is respected equally in all agencies and areas of the state.

Training

Protective services workers, counselors, assessment team members, information and referral workers, and emergency telephone personnel - indeed, most persons who participate in a protective services system for abused elders - need training. Traditional skills in case management, record keeping, community organization, and case work are also essential in the successful handling of these cases. For training suggestions in the field of elder abuse, see Chapter 10 of this Manual.

Funding

Although communities can begin the systems development work outlined above, certain vital services (such as emergency shelters) do not currently exist and require state or federal funding. Specialized skills and positions (such as the protective services worker) may not be available in many communities, and existing service providers may be unable to guarantee slots or units of service for abuse victims because of existing case loads or waiting lists. Priority setting at the state level (both programmatic and fiscal) is crucial if a uniform and serious effort is to be made to address the problem of elder abuse. Federal funds should also be specifically directed to this problem area.

CHAPTER 8

MODEL ABUSE REPORTING AND HANDLING LEGISLATION

In the past quarter of a century, family violence in America has become a major but unsolved societal problem. The "solutions" to the problem of child and spousal abuse have, more often than not, failed. Society must look at and learn from its past mistakes in dealing with child and spousal abuse in order to institute an effective, workable response to the problems of elder abuse.

Special Characteristics of the Elder Abuse Problem

While similar to child and spouse abuse cases, elder abuse cases present certain unique characteristics which indicate that the child or spouse abuse response systems cannot be applied unchanged to create elder abuse response systems.

Among the characteristics which make elder abuse cases different from spouse abuse cases are the following:

- The elderly victim is much more likely than the spouse abuse victim to be physically frail and therefore dependent upon the abuser for psysical care.
- The elderly victim may be mentally incompetent or deteriorating mentally for medical reasons associated with advanced age.
- The abuser of the elderly person is likely to be a blood relative and the elderly person often feels some responsibility for his/her character and therefore some personal guilt for any character defect.

In addition to the differences between child, spouse, and elder abuse, there are of course many parallels, the basic parallel being that virtually all of the cases involve violence within the family. This single common factor should be central to any planning that is done to create a response system.

A second, also obvious, yet critical, factor, is that all these cases involve two persons who need help - the victim and the abuser. Rarely will future abuse be prevented unless the needs of both parties are adequately addressed. Even legally enforced separation of the parties may be only a partial solution.

Some states have begun to address the issue of elder abuse by enacting mandatory adult or elder abuse reporting and handling laws. Other states have responded to adult abuse by enacting new civil and criminal remedies for persons abused by family or household members.

Chapter 5 provides a brief analysis of the criminal and civil remedies available in abuse cases, while this chapter contains analysis of the provisions which should be included in a mandatory abuse reporting and handling statute.

Most experts agree that mandatory reporting legislation unsupported by available and mandatory social and health services can result in serious harm to the elder person which can include displacement from the home, premature and unnecessary institutionalization, and wholesale "dumping" of our elders onto an inadequate state system. The key to effective mandatory reporting laws then is the availability of an array of supportive services.

In addition, legislation, drafted to include a means for providing social and health services to the abused, must set forth the framework for procedures which can establish surrogate authority in cases where the abused elderly person lacks the capacity to consent to services or manage his/her own life and property. Concurrent with these procedures there must be protection of the due process rights of the elderly individual.

Current Abuse Reporting and Handling Laws

By the end of 1980 approximately 15 states had adopted some form of an abuse reporting and protective services law.[1] This type of legislation varies from state to state but generally it includes some or all of the following:

- Access by social service workers to investigate abuse, neglect or exploitation;
- The mandatory reporting by certain categories of people of abuse, neglect or exploitation with immunity and confidentiality assured and penalties provided for failure to report;
- The voluntary and involuntary provision of protective services;
- The safeguarding of individual rights against inappropriate intervention.

The issues raised by this body of legislation are controversial as well as complicated. Any discussion regarding the best and most effective legislation involves complex questions of a legal, medical, and psychological nature. Answers must preserve the intricate and delicate balance between the principle that society has the duty to protect those unable to protect or provide for themselves, and the constitutionally assured rights of personal choice and individual freedoms.

Key Issues

The critical provisions of an abuse reporting and protective services law are those which determine how the conflict between individual rights and state intervention is resolved; whether there are sufficient service provisions to meet the needs of persons under the purview of the law; and how to establish payment procedures for services rendered. In short, essential provisions which should be considered are:

- The definition of persons covered by the law.
- The standards for reporting and investigating as they affect the rights of privacy and confidentiality.
- The right of access into private homes to investigate and to provide services.
- Due process safeguards in the determination and provision of services to involuntary clients.
- The establishment of adequate services to meet the needs of those under purview of law.
- Sufficient funding for services so that everyone in need can use them.

Persons Covered

The premise of protective services legislation is that persons exist in society who are unable to care for and/or protect themselves. Society, in the form of the state as parens patriae, assumes the responsibility of this care and protection. The criteria for state intervention should be one linked to the existence of abuse, neglect, exploitation, and/or abandonment and to a functional, mental, or physical inability to care for or protect oneself. The scope of the law and determination of need on the part of the person covered should be defined to assure that vulnerable persons who are abuse victims are protected and reached by services.

Of the states with legislation, a majority of the laws apply to persons "in need of protective services" or to those "incapacitated" and abused, neglected, or exploited.[2] Whereas the latter is linked to a physical determination, the former criteria, unless clearly defined in the legislation, fails to define an actual standard. This could result in potential confusion in mandatory reporting and in the increase of inappropriate intervention.

Other legislation relies upon the medical model of developmentally disabled infirmities of age and senility in the determination of the coverage of the law.[3] This determination must be questioned. These standards, as applied to the elderly, mean the diagnosis of acute or chronic brain syndrome, a condition typically thought to be an organic brain dysfunction. Evidence indicates that such a catch-all diagnosis may in fact be a self-fulfilling prophecy which masks conditions such as vitamin deficiency, depression, dehydration, over-medication, or injuries. The failure to treat these conditions results in further deterioration until organic dysfunction may actually exist. The physician often relies on information about the elderly person's condition provided by a caretaker. The opportunity for bias is obvious. Criteria discussed in this paragraph fail to take into consideration that some infirm elderly are in need of protective services but are not senile or suffering from the "infirmities of age" (organic brain syndrome). By either diagnosing them as such or denying them services by applying the standard more strictly, the elderly person suffers.

A standard linked to functional ability to care for and/or protect him/herself and the existence of abuse, neglect, exploitation, or abandonment[4] best defines the class in the manner most likely to include the largest number of persons in need, without increasing the likelihood of inappropriate intervention.

All but one state, namely Virginia, define need for services to be a question of behavioral or functional capacity. Virginia's standard refers to the individual in need who lacks sufficient understanding or capacity to make or communicate responsible decisions. This standard is clearly inadequate. Not only does it fail to address the central issue of the individual's ability to provide for his/her basic needs, but it bases the determination on the cognitive ability to make "responsible" decisions. This vague and value-laden standard opens the door for inappropriate intervention in cases where some surrogate authority decides that a particular decision is not "responsible," irrespective of the individual's ability to function and provide for his/her own needs.

Reporting and Investigation

Eleven states have explicit reporting provisions. Six of these states make reporting mandatory for anyone who has reasonable cause to suspect or believe that an individual is a victim of abuse, neglect, or exploitation. The remaining five states restrict reports to either practitioners of the healing arts solely or to a broad category of professionals including physicians, nurses, and social workers.

None of the legislation reviewed addresses the question of confidentiality as it applies to medical practitioners or the clergy. The assumption is that the law requires reporting even where confidentiality will be betrayed. This is in keeping with the notion of the importance of the societal interest in the preservation of life.

Several reporting provisions include a sanction of jail or fine for failure to report. The use and effect of such sanctions in adult protective services laws is still unknown. Similar sanctions contained in child abuse reporting laws have not served to increase the social responsibility for reporting the persons involved, nor have these provisions been seriously enforced.[5]

All of the reporting laws require that, following the filing of a report to the designated agency, the agency investigate, evaluate the circumstances, and make a determination of need promptly or within a specified period of time, such as 72 hours. The investigation must include a visit with the person believed to be abused and consultation with persons knowledgeable about the facts of the case. The ability of the agency to respond adequately to reports is a key issue which is linked to fiscal considerations. Some statutes include provisions limiting agency responsibility depending on availability of funding. This raises the question of whether these laws are backed by sufficient appropriations. A review of service provision systems in the states with protective services laws is necessary to shed light on the issue.

If an investigation indicates that the elderly person is or has been abused, neglected, or exploited and is incapacitated or in need of protective services, the agency will either develop a service plan or refer and contract out to another agency to develop such a plan. Voluntary services provision can begin if the individual consents.

Statutory reporting provisions must be coupled with procedures to assure the investigator or service provider access to the person believed to be abused. The agency can petition the court for injunctive relief to gain access upon proof of "reasonable cause to suspect" abuse, or to enjoin the caretaker from interfering in the provision of services. The burden of proof placed on the agency seeking injunctive relief is intended to prevent inappropriate intervention.

If services are refused or consent is withdrawn by the individual, the case must be closed except when the department/agency establishes that the individual lacks the capacity to consent. This standard is vague and the determination of capacity is rightfully left to the courts where the individual has some assurance that limitations on his/her rights will not be imposed without due process of law.

Provisions for Services to Involuntary Clients

At times an agency will find an elderly person who is in need of immediate assistance. If consent is secured, no legal action is needed. If consent is refused, the department must make an initial determination of the individual's mental capacity to consent as well as decide whether an emergency exists. If there is no doubt about the client's lack of capacity to consent, involuntary services may be provided only with court authorization secured pursuant to the state's guardianship statute or protective services provisions.

The area of emergency intervention raises the conflict between state interests and individual rights and many states lack well-defined procedures to regulate emergency intervention. Some states, such as Kentucky and Connecticut, do not provide for emergency intervention within the adult protective services statute. In these states, reliance is on voluntary service provision and injunctive relief if access is denied. Involuntary services may only be provided pursuant to estabilised guardianship and commitment procedures even when limited intervention would suffice. This approach is contrary to the doctrine of the least restrictive alternative.

Even more unsettling are provisions of statutes in states such as Alabama and Florida. In Alabama, notice of a hearing on the merits of protective placement must be given within 10 days and, if read in conjunction with the provisions on protective placement, a hearing must be held within 30 days of filing of the petition. The Alabama statute pertaining to emergency placement states:

> If the person is incapable of giving consent or <u>does not consent</u>, the department shall petition the court for an order authorizing the department to arrange for care for such person immediately. Upon a determination by the court that such care is urgently and immediately necessary..., an appropriate order ...shall be issued...to arrange for the placement of such person in an approved foster home, licensed nursing home, or other similar facility immediately.[6] (Emphasis added.)

The due process violations of Alabama's statute are glaring. The statute as adopted does not include an emergency services provision, but focuses solely on involuntary protective placement for persons unable <u>or</u> unwilling to consent. There is no question of competency here. Thus, the individual who is competent and refuses services may still be the subject of involuntary protective placement. The statute inadequately provides for representation, the right to be present at a hearing, and notice of the hearing. In other words, in Alabama, anyone who is deemed to be urgently in need of

care, whether competent or not, may be placed in a nursing home or other facility, excluding a mental institution, for anywhere from 10 to 30 days without an opportunity to be heard and with no assurance that any hearing held will adhere to the notion of due process.[7]

According to Florida's Adult Protective Services Act,[8] involuntary removal and placement can take place when authorized by court order. Although a preliminary hearing must be held within forty-five hours to establish probable cause for protective placement, custody can be continued for four days pending a hearing on the need for continuing services. These provisions do not include the right of representation, the individual's right to be present, or notice requirements. The statute also fails to provide for a determination of the individual's lack of capacity to consent, a prerequisite to involuntary placement. The only criteria spelled out in the statute is that an individual suffering from the infirmities of age who is being abused, maltreated, or neglected may be subject to this procedure. These standards are insufficient when held up against the constitutional guarantees of due process.

In addition, both the Alabama and Florida statutes fail to articulate the standard to be met in the course of a protective placement hearing. The potential for serious deprivation of personal liberty should require that the petitioner prove the facts alleged by clear and convincing evidence. A mere "preponderance standard" is inadequate when involuntary institutionalization is a likely result. Yet neither statute provides for this.

Other states, such as Tennessee, Virginia, North Carolina, Oklahoma, and Maryland, have adopted statutes which provide, in varying degree: due process standards, notice, limited intervention prior to a full hearing, and simplified petition upon sufficient facts of an emergency and inability to consent. Such provisions are more consistent with the notions of constitutionally protected rights of privacy and due process.

Yet this is insufficient. Despite such safeguards, there exists an inherent weakness and potential for abuse in statutes that rely on vague, undefined terms such as "lacks the capacity to consent." Medical and legal labels of incompetency and capacity are unusable because, in many cases, they include personal judgments on the part of the evaluator. Appropriate intervention can only be determined if functional disability can be identified and defined. By failing to address this issue, the statutes leave the door open to inappropriate intervention.[9]

Least Restrictive Alternative

Most states' protective services laws require that services provided should be the least restrictive of the alternatives available. This indicates an acknowledgement by the state of its obligation to provide care and protection with the least necessary restrictions on the person's liberty and civil rights.[10]

Although infringement of basic rights has been accepted by the courts when there is a "compelling state interest," the degree of infringement ought to be related to the degree of legitimate state interest in the protection of the individual, pursuant to parens patriae and the protection of society, pursuant to the police power. If this principle is accepted, the specific services provided and the manner in which they are provided, such as protective placement, should be appropriate to the individual case and allow for the greatest possible exercise of the person's liberties. Acceptance of this principle, unfortunately, does not guarantee that a genuine search for less restrictive alternatives will, in fact, occur; nor does it guarantee the availability of these services.

There are two major considerations that come into play in determining the most appropriate and least restrictive services:

- The determination of the need for services and their availability. Only one state makes use of a geriatric evaluation team at the point of involuntary placement to assure a suitable case plan and placement.

- The development and funding of community-based alternatives, such as congregate housing, foster homes, and extensive in-home services. If these alternatives are not pursued as options or are inadequately funded, the only placement available will be a nursing home facility or a hospital. Lack of such less restrictive alternatives makes the inclusion of least restrictive alternative requirements in any legislation almost worthless.[11]

In summary, existing statutes and remedies are, by and large, inadequate. Although predicated on the importance of utilizing the least restrictive alternative in treatment and placement, there is insufficient funding and development of such programs and alternatives to make this promise a reality. Legal remedies and intervention procedures do not always include service provisions that provide protection of the physical welfare or of the constitutional rights of the individual. There is too often reliance on inappropriate intervention procedures in violation of constitutional standards, because of the system's desire to do what is "best" for the client.

Even the best of laws cannot obscure the need to develop extensive social service networks to resolve the underlying problems which give rise to elder abuse cases. Nor can the issues be addressed without giving attention to the rights of the elderly in our society to choose for themselves how to live and, perhaps, how to die.

Recommendations for Provisions in Abuse Reporting and Handling Legislation

The following are recommendations for an abuse reporting law that mandates adult protective services. While accepting the basic principle that society has an obligation and duty to provide protection and care for particiular persons, the recommendations reflect concern for the rights of the individual to self-determination and to due process of law. It must again be noted that any mandatory reporting law without appropriate supportive services may do more harm than good in that it could result in inappropriate action being taken such as unnecessary institutionalization.

- The law should apply to persons 60 or older who are abused, neglected, exploited, or abandoned, and possibly to persons 18 and older who lack the physical or mental capacity to care for their basic needs and/or protect themselves.

- All important terms, such as abuse, neglect, exploitation, and abandonment, should be clearly defined in the statute.

- One state agency should be responsible for developing an adult protective services program for all citizens, and for providing these services either directly or through contractual arrangements.

- Within a short, prescribed period of time after noticing signs of abuse, a report should be required from certain categories of persons, including physicians, nurses, social workers, coroners, medical examiners, dentists, hospital staff, nursing home staff, homemaker and home health agency staff, clergy, adult foster care facility staff, and police officers. Anyone else who has "reasonable cause to believe or suspect" abuse may report this information to the designated agency.

- The identity of the reporting person should be kept confidential and be disclosed only with the consent of that person or by judicial process. A person acting in good faith who makes a report should be immune from civil and criminal liability.

- A person required to report but who fails to do so should be liable for a fine.

- One state agency should be responsible for receiving and investigating all reports. Each report received should be registered by the agency with all available information from the reporter.

  The agency designated to receive and investigate reports should have a system and personnel to:

  - receive reports around the clock;
  - keep records;
  - have knowledge of services available;
  - have access to services;
  - have a state-wide mandate; and
  - have the ability and trained staff to respond quickly.

  A centralized intake system should be geared into a regional response system if possible.

- The investigating agency should either provide services itself or coordinate service provision by subcontracting and referrals. This should be determined according to existing state service systems.

- The initial investigation should be conducted by persons trained in human services.

- Upon receiving a report made in accord with the law, the agency should investigate. This investigation should include a home visit and consultation with service agencies as well as contact with persons knowledgeable about the case (including the person making the initial report). The initial investigation for verification and assessment should be completed within a prescribed period of time such as 72 hours. The investigator should have access to a multidisciplinary geriatric team for consultation.

  - If the report is not verified, the case is closed. Safeguards should be instituted to protect the accused.

  - If the report is verified, an assessment of the individual's functional capacity, situation, and the resources available to the person should be made by a multidisciplinary team with expertise in the particular area of disability.

- In conducting the investigation, the agency may seek the assistance of law enforcement officials and the courts. If access is denied to the investigator, either by the elderly or incapacitated person or by a caretaker, the agency may petition for a court order to

enjoin interference with access to investigate. Such an order shall be issued upon specific facts showing that: (1) there is reasonable cause to suspect that the person in question is or has been abused, neglected, exploited, or abandoned; and (2) access has been denied to the representatives of the agency required to investigate such reports.

- Regulations should be promulgated which assure continuity of case management for investigation, assessment, case plan development, and service provision.

- Voluntary services should be provided upon consent to the elderly or incapacitated individual.

- The service plan developed should provide for the least restrictive alternative, client self-determination, and continuity of care.

- The services should be those which are necessary to prevent abuse, neglect, exploitation, or abandonment and should include medical care, mental health services, legal services, food, clothing, shelter, social services, and transportation.

- A fair hearing procedure should be developed and implemented so that any service plan can be appealed on denial of application for specific services or for failure to provide the least restrictive alternative.

- The agency should establish by regulation a sliding fee scale to be used in determining fees for services provided on a voluntary basis. However, no person should be denied services solely due to refusal to pay if it appears that the service denial will result in further abuse.

- The agency should maximize all available federal reimbursements for such services. There should be no charge to the individual in question for the cost of the investigation on the assessment.

- If an adult refuses services or withdraws consent, the agency must terminate intervention proceedings. This is consistent with the right of the adult to refuse treatment. The case is closed unless the agency seeks to provide services pursuant to involuntary provision procedures.

- Standards of non-emergency involuntary intervention and services provision should include the following elements:

  - Assessment of need and eligibility.
  - Clear and convincing evidence.
  - Least restrictive alternative; non-institutional placement where possible.
  - Geriatric/clinical assessment by social worker, physician, mental health practitioner, lawyer to assure appropriate case plan and placement should be required prior to any request for a court order.
  - Placement should not be in a mental institution, nor should any proceeding be a determination of incompetency.

- Any involuntary service provision or placement should only be authorized pursuant to a court order after a hearing on the merits of the case.

- The adult in question should be assured the right to counsel. If s/he is indigent, the court should appoint counsel. The adult should also have the right to be present and to cross-examine the parties involved. If counsel is waived, the court should appoint a guardian ad litem to act in the interests of the adult involved.

- Adequate notice should be assured. The client and any interested party should be served, at least 14 days prior to the hearing, with a copy of the petition and notice, including an explanation of the proceedings; the date, time, and location; the proposed service plan; and the rights of the adult in question to counsel, to be present at the hearing, etc.

- The court order for any protective placement should be specific and include reasons for finding the placement necessary and a statement that the placement is the least restrictive alternative. These facts should be stated in the court record also.

- The initial care plan submitted to the court should specify details of services, medical treatment, and relocation. The court order issued should be specific as to what services, treatment, and placement have been approved by the court. Any modification in the plan can only be made pursuant to court order.

- The court should limit the order to 6 months or less. Upon court review, it can be extended for another period of time (up to six months).

- The judicial determination authorizing involuntary intervention should be made according to the following: the adult bases decisions on delusions or hallucinations; is unable to make or implement decisions; or is unable to comprehend a decision's effect. The decision itself to refuse services should not be the sole evidence for finding the person lacks capacity to consent.

- The costs for involuntary services should be borne by the state unless a court, after determination of financial ability, orders the client to pay or unless the client agrees to pay.

- Standards of emergency involuntary intervention and service provision should include the following:

  - Emergency means that an elderly or incapacitated person is living in conditions which present a substantial risk of death or immediate and serious physical harm to him/herself or others.

  - A finding based on clear and convincing evidence that the adult in question is incapacitated and in need of services, and:
    - An emergency exists.
    - The person lacks the capacity to consent.
    - No one else can/is willing to consent.
    - The proposed order is substantially supported by the findings.

- In issuing an emergency order, the court should adhere to the following limitations:

  - The court should specifically order only those services necessary to remove the conditions creating the emergency.

  - Hospitalization or change of residence should not be included unless specifically ordered by the court upon a finding that such action is necessary.

  - Emergency intervention should be limited to a period of 72 hours, renewable for 72 hours upon a showing to the court of necessity to remove emergency conditions.

  - The court may appoint a temporary guardian with responsibility for the person's welfare and authority to give consent for emergency services (as ordered by the court) for the duration of the order if necessary to implement the order.

- The court should make sure that the elderly person is assured all rights except those limitations provided for in the order.

- Access to the premises should be ordered by the court to carry out the order in cases where voluntary access has been denied.

- Notice should be provided (including relevant and factual information on the basis of the petition) to the person, his/her spouse, children, next-of-kin, or guardian at least 24 hours prior to the hearing.

  This notice may be waived upon a showing that: (1) immediate and reasonable forseeable physical harm will result from the delay; and (2) reasonable attempts have been made to give notice to the above parties.

- Emergency Placement: If it appears probable from the personal observation of a police officer that an elderly person will suffer immediate and irreparable physical injury or death if medical care is not provided, and that person is incapable of giving consent, and that it is not possible to follow the hearing procedures, the officer should be able to transport the person to an appropriate medical facility for medical treatment.

  Notice of this action shall be given to persons listed above within 4 hours. A petition for emergency intervention should be required to be filed within 24 hours of this action and a hearing should be held with all due process guarantees within 48 hours of the transfer.

The same services available to victims should be available to the persons who have abused, neglected, exploited, or abandoned these persons. To meet this need, the state agency responsible for implementing the adult protective services system should develop formal cooperative agreements with other appropriate state and private agencies.

NOTES

1. Virginia: 63.1 Code of Virginia §§55.1 - 55.8
   Nebraska: Laws §§28-1501 et seq.
   Arkansas: Arkansas Statutes of 1947 Annot. §§59-1301 et seq.
   Alabama: Code of Alabama §§38-9-1 to 11
   North Carolina: Article 4A General Statutes of North Carolina §§102-108 et seq.
   Florida: Florida Statutes Chapter 77-336, §§409.3631 et seq.
   South Carolina: 43 South Carolina Laws §§29-10 et seq.
   Connecticut: 46a C.G.S.A. §§14 et seq.
   Oklahoma: 43 Oklahoma Statutes Annot. §§801-810
   Kentucky: Kentucky Revised Statutes Chapter 209.010 et seq.
   Tennessee: Tennessee Code Annot. §§14-2301 et seq.
   Maine: 18 M.E.S.A. §§3601 et seq.
   Montana: Revised Codes of Montana 71-1914 et seq.
   Michigan: M.C.L.A. §§400.14
   New Hampshire: New Hampshire Revised Stat. Chapter 161-D:1 et seq.

   Minnesota, Missouri, Arizona, and Vermont enacted statutes in 1980.

2. Statutes of Connecticut, Michigan, Oklahoma, New Hampshire, Virginia, Maine, and Washington.

3. Statutes of North Carolina, Florida, and South Carolina.

4. Connecticut is the only state that presently includes abandonment.

5. "Evidentiary Problems of Proof in Child Abuse Cases," 13 Journal of Family Law 819 (73-74).

6. Code of Alabama, §38-9-5.

7. Id.

8. Florida Stat. Ch. 77-336, §§409.3631.

9. An example can be found in the case of State v. Northern, 53 S.W.W 2d 197 (Tenn. Ct. App.) cert. denied, id. (Tenn. 1978), appeal dismissed as moot, where the court held, in applying Tennessee's protective services statute, that although the individual was found to be "lucid and apparently of sound mind generally," she suffered from a delusion that rendered her unable to comprehend the gravity of her condition that required amputation of her feet to save her life (563 S.W. 2d at 209-210)(1978). She was judged legally incompetent to consent to the operation. The court authorized the "necessary" medical treatment without due regard for the right of the individual to refuse such treatment, or the

apparent contradiction in their reasoning. For an almost identical case with the contrary decision, see Lane v. Candura, 36 N.E. 2d 1232 (Mass. Appeals Court 1978).

10. Not all states have articulated this as a principle and those which have mention it in the "legislative intent" section accompanying the statute.

PART IV:
TRAINING AND PUBLIC EDUCATION

CHAPTER 9

TRAINING

Training should be a major component in any effort to assist abused and neglected elders. Elder abuse and neglect are "hidden" under-reported problems, and few understand their scope. Because they are extremely complex problems, even fewer individuals have the background and skills needed to handle individual cases or to develop effective policy responses.

Those who work with elders often overlook elder abuse as a potential problem. The older person who "falls down a lot" may be suffering from more than the frailties of advanced age. Until workers are trained to identify and handle properly cases of abuse and neglect, the problems may continue to go undetected and unresolved.

Program administrators also need training in elder abuse. They face difficult resource allocation decisions and will have to be educated about the nature and extent of the problem. They will also have to be persuaded of the need to develop treatment and prevention programs in cooperation with other agencies.

Advocates and activists must be kept abreast of both the current research and efforts at systemic change to involve them in the search for solutions.

State and local legislators must be reached. They must be presented with the facts and figures and offered sensible legislative recommendations.

In summary, training can serve to:

- Increase general awareness of elder abuse.
- Improve the capacity of service workers to assist abused elders.
- Prepare administrators to develop responsive service delivery systems.
- Stimulate activists and advocates.
- Educate lawmakers about the problem and potential remedies.

Who Should Be Targeted for Training?

There are two basic categories of individuals who should receive training:

- Those who provide services and have direct contact with the elderly.
- Those who make or influence decisions on service delivery, fiscal allocations, and legislation.

Direct service workers may include:

- visiting nurses
- home health aides/homemakers
- other in-home support service providers, e.g., drivers for meals-on-wheels programs
- public health nurses
- hospital social workers
- hospital emergency room personnel
- police
- protective services workers
- senior center staff
- members of councils on aging
- legal aid staff, lawyers, and paraprofessionals
- family service agency workers
- mental health center staff
- nutrition program staff

Policymakers include legislators at the local and state levels and planners and administrators from direct service programs, planning agencies, legal services projects, and state offices concerned with aging, domestic violence, mental health, protective services, and law enforcement. Advocates and activists, such as the Gray Panthers, should be included in the policymaker category for training purposes.

What Kind of Training Should Be Offered?

Training sessions should be geared to the needs and interests of the audience. Care providers will want to know the nature of the problem, identification and investigation procedures, and intervention strategies. Presentations to policymakers might begin with an overview of the topic but should focus on systems issues such as resource development and legislation encompassing rights and remedies.

The following is a "menu" of training topics geared to the direct service provider:

- Elder Abuse as a Component of Domestic Violence
- Research on Elder Abuse: State of the Art
- How to Identify and Assess Cases
- How to Investigate Cases
- Legal and Ethical Issues in Handling Cases of Elder Abuse:
  - Access to Client
  - Right to Privacy
  - Confidentiality
  - Client Consent
  - Assessing Competency
- How to Develop and Implement Pre-planned Responses
- Elder Abuse as a Family Problem: Serving the Victim and Abuser
- How to Inventory Resources and Service Gaps in Your Community
- Avoiding Burnout

For an audience of administrators and legislators, the approach should focus on basic information and on developing local and state response systems rather than skills development. Topics might include:

- An Overview of Family Violence and Elder Abuse
- How Other States Have Responded to the Problem of Elder Abuse: Existing Statutes and Legal Remedies
- Characteristics of an Integrated, Comprehensive Protective Services System
- Assessing and Analyzing Resources and Service Gaps
- The Limits of Current Knowledge and Directions for Further Research

With a diverse audience, it is possible to provide a mixture or topics. At present, most people need a basic introduction to the problem. Very few will find any of the proposed topics irrelevant or a repetition of what they know.

Training Design and Delivery: Who, What, and How

Training design is a question of packaging - how should the material be organized and who should deliver it? This section covers a number of practical considerations:

- Deciding on a format.
- Identifying resource people.
- Using the materials in this manual.
- Tips for trainers.

Deciding on a Format

A training session can vary from a one-hour inservice workshop to a three-day residential conference. How long the session is and how the materials are presented will depend primarily on what the convenors hope to accomplish. Is the goal to increase general awareness about the problem of elder abuse? To impart skills to workers? To educate lawmakers? Carefully consider the goal of the session; then plan the right format to achieve that goal. Budget constraints, the number of participants, the setting, and timing will also influence the design of the training.

Identifying Resource People

Who can help to deliver the training? There are few experts in elder abuse treatment and prevention. You may want to check with the local university to see if any professors are doing related work or might be available to explain the highlights and limitations of existing studies. Directors of programs dealing with other forms of domestic violence, such as child abuse and spouse abuse, will have valuable experience to share. They may also find that their programs are handling some elder abuse cases. Individuals who have seen and handled cases of elder abuse, whether lay persons, social workers, or medical or mental health professionals, should be encouraged to make presentations. A lawyer who has researched relevant state laws should be included. A final suggestion is to use the materials contained in this manual and become an "expert" yourself.

Using the Manual

This manual presents much of what is currently known about elder abuse and neglect. Part I reviews the literature on elder abuse. Part II offers practical guidance to the direct service worker on handling individual cases. The protocols included are an invaluable model for developing pre-planned responses. Part III gives suggestions to policymakers on model delivery systems and legislation. Part IV addresses training and public education. Trainers should consider excerpting relevant portions for training sessions.

But one more publication will do little to protect the victims of elder abuse and neglect. It is up to individuals to use the information this manual contains to educate and mobilize their communities.

Tips for Trainers

The key to successful training is to pay careful attention to educational process as well as to substantive content. You should know your audience - their strengths, interests, and needs. Make your presentation clear and varied. There is more to training than having experts tell the audience what they know. Here are a few basic principles that may be of assistance:

- Variety is the spice of life. The creative use of teaching techniques can transform a presentation. Appeal to as many senses as possible. Supplement mini-lectures with visual aids and handouts. Vary the size of the working group. Use techniques such as brainstorming and role plays to energize the group. Guide people through the protocols included in Part II. Use the hypothetical cases which follow the sample training agenda at the end of this chapter.

- Establish a framework. Set the stage. Each presentation should have a clear introduction stating the purpose of the session, the areas which will be covered, and the format to be followed. A simple outline in poster or handout form can be helpful in this process. A brief summary of the session serves to reinforce learning.

- Be prepared. Attention to logistics insures that things run smoothly and valuable training time is not wasted searching for materials, room numbers, electrical outlets, handicapped-accessible bathrooms, etc.

- Evaluate your efforts. Elicit trainee comments on the organization and content of the presentation(s) and on your teaching style. This can be done informally at the close of a session or by means of a written evaluation form.

Summary

Training can bring key actors together to educate themselves about a common problem and facilitate the development of cooperative solutions. There needs to be a shared recognition of the nature and scope of elder abuse and neglect. Those who work directly with elders need to be trained to identify cases and develop strategies for responding to emergency and chronic situations. Those who set program policy, allocate resources, and make law must be persuaded to respond to the problem of elder abuse and neglect in a comprehensive and coordinated fashion.

SAMPLE AGENDA FOR TWO-DAY TRAINING SESSION FOR DIRECT SERVICE WORKERS

DAY 1

9:00 - 9:30	Introduction of Participants and Training Personnel
9:30 - 10:30	Overview of Elder Abuse and Neglect - Summary of Data - Causation Theories - Family Context
10:30 - 12:30	Adult Protective Services - The Nature of Protective Services Cases - Elements of the System - Identification of Abuse and Neglect Cases - Initial Assessment and Referral - Developing and Using Protocols
12:30 - 1:30	Lunch
1:30 - 3:00	Interviewing Techniques - Hypothetical Case(s) - Role Plays
3:00 - 5:00	Overview of Relevant Statutes and Legal Issues - Domestic Violence Statutes - Competency and Consent Issues - Access/Right to Privacy - Abuse Reporting Statutes

DAY 2

9:00 - 10:00	Systems Building/Interagency Cooperation - Professional Attitudes - Turf Issues - Dealing with Conflicts - Forging the Agreement

DAY 2 - continued

10:00 - 12:00	Hypothetical Cases - Role Plays - Issue Spotting - Brainstorming - Protocols - Discussion
12:00 - 1:00	Lunch
1:00 - 2:00	Informal Presentation of Actual Cases
2:00 - 3:00	Worker Burn-Out
3:00 - 4:30	Developing Local Action Teams
4:30 - 5:00	Evaluation

HYPOTHETICAL CASES

Use of case profiles and hypothetical cases is an essential ingredient of the skills training social service, health, mental health, legal, and community workers need to handle elder abuse and neglect cases. This section contains hypothetical cases to use in practicing with the protocols in Part II, Chapter 6, as well as additional hypotheticals for discussion and role play.

To get the best results from the hypothetical cases, the trainer should stipulate the applicable laws and available resources. The trainer can use either the laws and resources of a particular state or develop hypothetical laws and resources typical of the situations the trainee will face.

There are no set "answers" to the problems presented in the hypothetical cases, just as there are usually no easy short-cuts in handling real abuse and neglect cases. In these hypothetical cases, as in all abuse and neglect cases, there are numerous "logical" options to be carefully explored by the client and worker. Where no trainer with substantial experience is available to guide the group toward practical solutions, the training group should "brainstorm" answers together.

Role play should be included in working through these cases. Role play is a highly effective, multipurpose teaching technique that can be used in many different ways. It is particularly appropriate for direct service workers handling abuse cases since it dramatizes the subtleties and complexities of human interaction. Role play has a number of other advantages. It can:

- Create involvement and commitment on the part of the trainees by requiring active participation.
- Serve as a bridge between theory and action, enabling trainees to make an effective transition from understanding to practice.
- Provide a safe learning environment where new approaches and behaviors can be tried out without the consequences of failure.
- Make actual, concrete behavior available for analysis, feedback, and improvement.
- Help trainees overcome prejudices and strong emotional reactions.

For example, a role play that encourages empathy and understanding for both abuser and victim can help direct service workers escape the impulse to stereotype and instead understand and evaluate accurately the dynamics of a family situation. This could be achieved by breaking the trainees into groups of three, with each person in a group playing in turn the interviewing worker, the abuser, and the victim. Later the groups could reassemble to share feelings and observations.

Case #1: Consenting, Competent Client

James Dolan, a 70 year old retired draftsman, lives with his daughter-in law, Marie, and grandchild in a small, run down house owned by his son, James Jr. Mr. Dolan suffers from debilitating arthritis of both knee joints and walks slowly with a walker.

Mr. Dolan's arthritis has gradually worsened since his retirement five years ago. Three years ago, after several bad falls, he agreed to sell his own home and move in with his son and daughter-in-law. Mr. Dolan turned the proceeds from the sale over to his son. Since that time, Mr. Dolan has lived in a small (9' x 11') converted sewing room on the second floor of his son's house.

While Mr. Dolan can care for himself in general, he does so with great pain. He has difficulty completing precision tasks, such as cutting his food or shaving, because of some swelling in his fingers. He enjoys reading and in the past has often asked Marie to bring him books from the town's library.

Last year, James Jr. left his wife and withdrew most of the money from their joint savings account. He continues to provide some support but moves around frequently and has given no clear indication about the future status of their marriage. James Sr. remains in the house with his daughter-in-law and grandson.

During the past year, Marie has gradually withdrawn from all social contact. Last month she removed her 4 year old son from the day care center he attends. She has also stopped most care for her father-in-law, who remains isolated in his room, and who frequently goes without meals.

Last week, Mr. Dolan, frustrated and lonely, dressed himself as best he could and managed to get downstairs with great difficulty. Marie found him in the front yard and ordered him harshly back into the house. When he fell, Marie did not help him up.

A neighbor who witnessed the fall offered to help Mr. Dolan upstairs. Marie declined the offer, saying, "If he got down himself, he can damn well get back up there too," and asked the neighbor to leave her yard. Mr. Dolan, apparently in pain looked at the neighbor and said, "Can you help me?" The neighbor, concerned and frightened, called the welfare department and asked what could be done to help "the old man". "He doesn't look so good," said the neighbor. "I think he hurt himself when he fell." The neighbor indicates that Mr. Dolan has asked for help before. The neighbor also said she was fairly certain the daughter-in-law will deny access to Mr. Dolan.

Case #2: Competent, Consenting Client*

Mrs. Georgia Vickers is a 65 year old, recently retired clerk who lives with her 68 year old husband, Thomas, in a single family house which they own (though the title is only in Mr. Vickers' name). The couple have three adult children but only one, Matthew, lives nearby. During an infrequent visit Matthew Vickers witnessed an argument between his parents. In the course of the argument Mr. Vickers slapped his wife because she would not stop "complaining". Matthew intervened and was then ordered from the home by his father. This was not the first time that Matthew had observed his father hit his mother; however, he now realized that his father was becoming increasingly violent and dangerous.

The next day Matthew Vickers telephoned the local Area Agency on Aging because he wanted to know what kind of help was available. The AAA referred him to Mid-State Home Care Corporation. The intake worker listened to his story and explained what services the agency offered. The worker suggested that a case manager make a home visit to do an assessment, but she indicated that this could take place only with the client's consent. Matthew telephoned his mother and told her what he had done and asked if she would be willing to have an assessment interview. She agreed to meet with the case manager but not in her own house because she feared her husband's reaction.

Mrs. Vickers set up a time to meet with Rita Catalpa, a Mid-State case manager, at Ms. Catalpa's office. During this initial interview it emerged that Mrs. Vickers had been the object of emotional abuse for years. The physical blows were a comparatively recent thing, but they caused Mrs. Vickers an enormous amount of grief. Mrs. Vickers explained that, despite her anxiety and unhappiness, she had done nothing because she feared the loss of her house. Not only the house but all bank accounts and insurance policies were in Mr. Vickers' name. Mrs. Vickers said that she knew her husband well enough to know that if he were provoked, he would try to seize all of it, just to frustrate her.

Catalpa listened to Mrs. Vickers' recitation of abuse and threats and promised to try and help her find a solution. She explained that cases such as Mrs. Vickers might be complicated, and sometimes require help from other professionals. Rita Catalpa asked Mrs. Vickers' permission to speak with an attorney about possible alternatives. Mrs. Vickers consented on the condition that she remain anonymous.

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* This case is designed for a non-community property state that has a Domestic Violence Act.

Catalpa met with Leslie Miller, an attorney from the local legal services project. She explained Mrs. Vickers' problems to Miller and was candid about the older woman's fears of material loss. The attorney explained the Domestic Violence Act provisions and how the act might be applied to protect Mrs. Vickers' person as well as her property. Miller noted that the client could petition the court for a temporary restraining order, a vacate order, and an order for temporary support. The attorney also pointed out that the client might consider divorce proceedings, establishing her right to some of the property through a divorce settlement. In either case, though, the client would have to confront her husband in a courtroom and she might suffer a temporary loss of economic support.

After her meeting with Miller, Rita Catalpa telephoned Mrs. Vickers. The couple had just ended another argument during which Mr. Vickers had struck his wife and pushed her into a wall. Mrs. Vickers was very upset and begged Catalpa to "do something". Catalpa asked Mrs. Vickers if she would speak to an attorney. When Mrs. Vickers agreed, Catalpa called Miller and asked if it would be possible to meet at the client's home. Miller said she would rather interview Mrs. Vickers privately at her office. Catalpa agreed to drive Mrs. Vickers to the legal services office.

Having talked with her attorney, Mrs. Vickers decided to petition the court for a vacate order and an order for temporary support. Miller suggested that Mrs. Vickers might not want to be alone when her husband was served with the court order to appear for a hearing. Miller called Catalpa and asked for an emergency placement for her client until the hearing had occurred. Catalpa explained that the town really had no provisions for housing emergencies.

Comments to Trainer

There are at least three possible conclusions to this case:

a) The court may grant Mrs. Vickers' request and her husband will have to move elsewhere. Mr. Vickers will have to pay support.

b) The court may grant the petitions but Mrs. Vickers may agree to attempt a reconciliation with counseling support. (In this case, the restraining order acts as an insurance policy for the client while she continues to live with her husband.)

c) The court may refuse to grant petitions. Case management then would have to deal with Mrs. Vickers' need to protect herself.

Case #3: Competent/Non-Consenting Client

Gretchen Anderson is a 75-year-old widow who worked for twenty years as a waitress. Mrs. Anderson has lived with her 50-year-old son Mitchell since he was released from Bryce State Hospital five years ago. Mitchell had been committed by his estranged wife when he was 35 and actively psychotic. He spent the next ten years of his life medicated on a chronic care ward. During the deinstitutionalization process, a hospital social worker arranged community placement in a foster care home. The house parents were intolerant of Mitchell's lapses in hygiene. Mitchell's mother, an increasingly bitter and suspicious woman since retirement, agreed that her son could share her apartment so long as he paid his share of expenses.

The two lived together with only minor difficulties until a year ago when Mrs. Anderson was terminated from the Supplemental Security Income (SSI) program because her bank account exceeded her resource limit. Mitchell's aftercare social worker from the state hospital offered to help Mrs. Anderson but she initially refused. When her bank balance had dropped very low, however, she telephoned the aftercare worker, Bruce Stevens, and asked for help. Mrs. Anderson had begun "borrowing" money from Mitchell's disability checks and he sometimes became argumentative about his mother's tampering with his money. Mr. Stevens refers Mrs. Anderson to the Adult Protective Services office for assessment and SSI advocacy.

Ellen Jackson, a case worker, visits Mrs. Anderson after a brief telephone consultation with the state hospital worker. Jackson begins asking Mrs. Anderson some general questions when Mitchell enters the living room. He stands and slowly rocks back and forth until the case manager starts touching on financial issues. As Jackson asks a question, Mitchell says to his mother, "Don't answer that." Jackson smiles at Mitchell and explains that Mrs. Anderson has already answered these questions once in order to get SSI. Mitchell becomes more defensive and again pleads with his mother not to answer. Finally, when Gretchen Anderson attempts to tell her current bank balance, Mitchell becomes very defensive, runs around behind his mother's chair and roughly covers her mouth with his hand. "Don't tell her anything. She wants to send me back. I know she does. I'll kill you if you tell her!"

Jackson, fearing for both herself and her client, rises slowly to leave. She says in as steady a voice as she can muster, "I must go now, Mr. Anderson. Why don't you let go of your mother? I don't want to hurt either of you. See, I'm even leaving the papers we were filling out here." As she moves toward the door, Mitchell releases his mother, who now has a cut lip. He is still clearly agitated. Mrs. Anderson transfers all her anger to Jackson and screams at her to get out and leave them both alone.

Immediately after leaving the Anderson apartment, Ellen Jackson drives back to her office and calls Bruce Stevens. Jackson tells Stevens what has just happened and asks if Stevens can pay a quick visit to the Anderson house to try to defuse the situation. Stevens does so and is refused admittance by an angry Mitchell. Behind Mitchell, Stevens sees Mrs. Anderson holding her side and shouting, "Leave us alone."

Stevens returns to his office and calls Ellen Jackson. Jackson asks whether Mitchell can be readmitted to the state hospital or nearby community mental health center for psychiatric evaluation. Stevens counsels against such action, saying that this is the first such occurrence of aggressive behavior since Mitchell's disastrous experience in a foster care setting. He also points out that the uproar seemed inadvertently to be the result of Jackson's visit. Stevens further notes that neither Mitchell nor his mother have asked for help and that readmitting Mitchell may make matters worse for Mrs. Anderson from both an emotional and a financial point of view.

Jackson reluctantly agrees with Stevens but continues to press her concern for Mrs. Anderson. Stevens notes that he has another regularly scheduled visit to the Anderson home coming up in a week. He offers to act as a link with the Adult Protective Services providing Jackson is willing to coordinate services through him. Stevens suggests that Jackson develop some service care plan alternatives for Mrs. Anderson as well as investigate emergency financial and shelter possibilities. Jackson consents to Stevens' suggestions and they propose a joint conference after Steven's next visit to the Anderson's.

Case #4: Competent, Non-consenting Client

Helen Morrissey is an 86-year-old woman of independent means and spirit who lives with her niece Anna, aged 68. Anna is a slightly bewildered diabetic who dotes on her frail, bedridden aunt. They live in a large house in what has become a seedy area of town. There are frequent break-ins in the neighborhood and Anna fears being mugged. She has taken to locking doors against most callers and only goes out once a week to do shopping and errands.

Helen has noticed Anna's increasing obsession with possible harm and has sometimes suffered because of it - Anna frequently postpones shopping trips for days on end because of her fear of going outside. As a result, food supplies run dangerously low and meals are some-

times skimpy. Helen fears that someday Anna, who is becoming forgetful, will not take her medication and go into a coma. Helen knows she could not help Anna if this happens. As a precaution, she has the telephone moved to her bedside, within easy reach.

A friend visiting Helen for the first time in several months notices her drastic weight loss and the sloppy condition of the house. She raises these issues with Helen only to be told, "Mind your own business, deary. Anna and I have been together for 14 years and I'm not going to change things now."

The friend, still concerned, calls the local agency which provides in-home supportive services and asks them to talk to Helen. The case manager calls and Helen tells her to "butt out" and hangs up.

A few weeks later, the case manager receives another call from Helen's friend and is informed that Anna was hospitalized a week ago in a diabetic coma. Anna is recovering and Helen, now being cared for by the friend, still refuses to consider a change in her life style. Anna insists she is well and must soon return home to care for and protect Helen. Helen's friend is very worried.

Case #5: Emergency

The Ashton police department referred Mr. Luther Hodges to the welfare department after it had received an anonymous telephone call about an elderly man supposedly living in an abandoned house. The police officers sent to the address reported that they discovered a man of approximately 70 years who appeared to be living alone in an almost empty five-room house with only a few pieces of dilapidated furniture. The man, who identified himself as Luther Hodges, said that he had been living with his son and daughter-in-law since his wife died two years before. Mr. Hodges' son had decided to take a ship building job in Virginia and he had specifically rejected the idea of taking his father along. One of the officers asked Mr. Hodges if he wanted to speak to a social worker and Hodges refused the offer.

Two days after the initial report, the Ashton police received another call about Mr. Hodges, this time from the owner of the house. The owner indicated that he has sold the property where Mr. Hodges currently lived and that development was to begin within a week. Before returning to the house, the police contacted the welfare department and asked if a worker could accompany them on their visit to Mr. Hodges. The case management supervisor agreed to assign a worker but noted that police presence beyond the initial introductions and the expla-

nation of the problem might be counterproductive. While the police accepted this provision, they pointed out that Mr. Hodges was soon to be in violation of the law.

Ralph Yates, the worker assigned to the case, arrived at Mr. Hodges' house with the police Tuesday afternoon. The police explained to Hodges that he was living in a house which would be demolished in a week and that the owner of the property would take legal action to remove him if that were necessary. After introducing Yates, the police departed.

As the interview proceeded, Hodges emerged as a somewhat defiant 75 year old man who fully expected his son to return for him any day. He admitted that they had argued previously but he seemed unable or unwilling to grasp the idea that he had been abandoned. Hodges did not know his son's new address nor was he sure what sort of benefits he received because his son or daughter-in-law had always handled his checks. He had only five dollars on him and was uncertain about whether he had a checking or savings account. Yates explained that at least until Mr. Hodges' son did contact him, it might be wise to explore some alternative living arrangements. Hodges explained that he could not leave "his" house because he had no money and his son would return to that location looking for him. Yates said that he could help with emergency funds and that neighbors could be alerted to look out for Mr. Hodges' son. Yates also promised to help with filling out a change of address card for the postman. Finally, Yates reminded Hodges that ultimately the police would force him to leave anyway. Despite this, Hodges refused to leave.

Case #6: Emergency (Competent/Non-Consenting)

Mrs. Grace Lovins is a 68 year old woman who has been a client of the welfare department for approximately two years. The client is a recovered alcoholic with some brain damage who smokes cigarettes incessantly. She has periodic lapses in sobriety usually associated with reactive depression or stress. Mrs. Lovings first became a welfare client in 1977 after a fire destroyed the apartment building where she had lived. The Welfare department assisted by re-housing her in an elderly building and has maintained monthly case management visits for client monitoring since that time. Chore services have been arranged on an as-needed basis.

Mrs. Lovings is a dependent and sometimes confused person. She is generally able to focus on people but has trouble with time and place. She has occasionally gone out unescorted and been unable

to find her way home. She once sat in a hospital waiting room for ten hours because the Senior Transportation Van neglected to pick her up.

Mrs. Lovins has had the same case worker since the fire. Carolyn Jones, the worker, genuinely likes her client though she admits to some uncertainty about Grace's coping abilities. The only other significant person in the client's life is another resident of Grace's building, a wheelchair-bound former alcoholic named Peter Simpson. Mrs. Lovins variously refers to him as her "boyfriend" or her "drinking buddy". Since both have been known to get drunk and engage in violent arguments, the other residents of the building rarely interact with them. Jones has never determined how aware the client is of her extreme isolation. Peter is frequently hospitalized and has asked that Grace visit him. She refuses to go because of a long-standing fear of hospitals complicated further by her previous experience of being left in the waiting room.

Mrs. Lovins has complained lately about abdominal pains and Carolyn Jones has tried to get her client to see a doctor. The worker has suspected an ulcer aggravated by occasional drinking. Mrs. Lovins is adamant in her refusal to seek medical care.

Jones received a frightening telephone call from Mrs. Lovins this morning begging the worker to come and visit. Initially suspicious that her client was lonely and possibly drinking, the worker refused, but since she had two other clients in the same building to reassess, she finally agreed to "look in" for a few minutes.

When Mrs. Lovins answered the door, Jones was shocked by her appearance. The client wore a blood-stained house coat and looked as if she might pass out any minute. $300 was scattered on the kitchen floor. Jones could not get an explanation from her client about the money or the blood stains. As the client walked unsteadily, she trailed drops of blood. Mrs. Lovins was inarticulate with fear and embarrassment. She refused Jones' offer of an ambulance.

Unclear about what to do, Jones called her supervisor. In the meantime, Mrs. Lovins lay down on her couch with a cigarette and was moaning. Jones' supervisor said that he could offer no suggestions but that if Jones did call the ambulance, it was her responsibility.

Case #7: Incompetent, Emergency

Mrs. Mavis Riley is an 80-year-old woman who lives alone in an indescribably cluttered apartment on the third floor of a two-family house. The widow of a fire fighter, Mrs. Riley has an adequate income derived from Social Security and her late husband's pension. The client has lived in this same apartment for the past thirty years. The house had previously been owned by Mrs. Riley's brother; however, he sold it to a Reverend Anderson, a Methodist minister, ten years ago. The brother, now 90 and quite frail, lives in a suburb. He has not seen his sister in seven years. The only other known relative is a 53-year-old daughter, Diane, who lives alone in a nearby industrial town. Diane currently works in a fish processing plant. She has a history of past mental hospital admissions and copes marginally with life. Diane is her mother's only link with the outside world and her weekly visits are the client's sole means for obtaining food on a regular basis.

According to Diane, Mrs. Riley has always been a strong-willed, rather eccentric woman. Two years ago, however, the client was robbed on the street and beaten badly. After six weeks in the hospital, she returned to her house. Upon her return or shortly after it, the client's behavior became increasingly erratic. Mrs. Riley began refusing to pay Reverend Anderson the rent because she claimed that her brother owned the house and "he never charged any rent!" Anderson's sense of responsibility initially prevented him from doing anything to recover his losses. He has now filed for eviction, but only after Mrs. Riley failed to pay her rent for twelve months. Mrs. Anderson, a former social worker, has become increasingly concerned about Mrs. Riley's effect on her two pre-adolescent children. Mrs. Riley has frequent screaming conversations with herself and she is occasionally assaultive. Reverend Anderson recently left a case of canned soup in his tenant's kitchen while she was napping; she responded to this by throwing the cans of soup in the direction of the children as they returned from school.

Mrs. Anderson contacted the senior health and home services program about one month before the eviction papers were filed. She explained the case professionally and admitted some of her own ambivalence. Mrs. Anderson said that Mrs. Riley ought to have enough money to acquire new housing since she hadn't cashed her benefit checks in over a year. Mrs. Anderson did agree that it would be difficult to find anyone who would put up with the tenant's behavior, but she felt that her family had borne the burden of Mrs. Riley long enough. Mrs.

Anderson offered to help the home care worker with access and information; however, she was adamant that nothing, not even her profound sense of personal sadness, would forestall the eviction, even if that meant hiring a constable and/or calling the police to enforce the eviction notice.

Maryanne Bluesky, the case worker assigned to Mrs. Riley, makes three attempts to see the client. On each occasion the client refuses to open the door. Finally, Bluesky is admitted with Diane after one of the daughter's weekly shopping trips. Mrs. Riley is confused. Her thoughts are loose and tangential, but she seems to be able to check the groceries which Diane has purchased. On a radiator sits mouldering a pan of Duncan Hines brownie mix. Bluesky ultimately gets the client to agree to see her and a "doctor" within a week.

When Bluesky and her psychologist consultant, Dr. Tanaka, arrive on the following Tuesday, Mrs. Riley refuses to let them in. She says that they've come on the wrong day; they were "supposed to come on Tuesday." Bluesky gently reminds Mrs. Riley that it is Tuesday. "Not in this apartment, it isn't," shouts Mrs. Riley as she slams the door. Dr. Tanaka looks at Bluesky and says that the visit is a waste of time and that she will only see Mrs. Riley in her office - and why do case managers always give her such rotten referrals anyway?

Blueksy sets up an appointment with Diane Riley to discuss the possibility of a guardianship for her mother. Diane becomes very emotional during the interview and says that she's fearful of losing her job if she has to take off any more time on her mother's behalf. She tells Bluesky not to call her at work any more because her foreman has complained about it. When Bluesky telephones Mrs. Riley's brother, he says that he wants nothing to do with his sister because "Mavis is crazy...always has been." The eviction is scheduled for the next day at 8 A.M. Mrs. Anderson has sent her children away to avoid the scene. She has alerted the police and plans to have her attorney present.

Case #8: Possible Incompetent Client

George Simpson, an 81-year-old retired drapery maker, lives with his 75-year-old sister, Agatha, in a building for older people. Because of multiple physical ailments, Mr. Simpson has been hospitalized three times in the past six months. His follow-up care has included visiting nurse treatments twice each week since the initial hospital stay.

In the past two months, Mrs. Turner, Mr. Simpson's nurse, has noticed a significant drop in her patient's level of functioning. Mrs. Turner is concerned not only with Mr. Simpson's mental state, but also with unexplained bruises and scratches which she has noticed during several examinations. As the older man has grown more dependent, his sister seems more intrusive and demanding. An increasing amount of Mr. Simpson's care has become Agatha's responsibility. She clearly resents the responsibility and openly ridicules her older brother for his increasing dependence.

At Mrs. Turner's suggestion, Al Torelli, a protective services worker from a private agency, begins visiting Mr. Simpson. After a month of casework, however, Mr. Simpson has not acknowledged that there is any problem with abuse and declines further visits. He does agree that Torelli may call his only other relative, a son named Henry who lives in New York City.

Torelli informs Henry of the situation. Henry Simpson decides to hire an attorney to move for guardianship in order to place his father in a nursing home. When George Simpson receives notice from the court about the guardianship hearing, he becomes furious. He accuses both his sister and his son of "tormenting" him. Mr. Simpson asks Torelli to help him fight the guardianship. Torelli believes that a nursing home placement would be harmful, but is not certain whether the problems in the home can be solved.

Case #9: For Case Worker-Client Interview Role Play

You have been asked to role play a client named Mrs. Mattie Vernon. Mrs. Vernon is a 74 year old widow who lives with her disabled son, John, in a single family house. Mrs. Vernon has one other child, a married daughter named Susan, who has an apartment in the same town. Mrs. Vernon has been diagnosed as having a congestive heart conditon. John, a Korean conflict veteran, has diabetes and a suspected drinking problem. Both people receive SSI, John for his disability and his mother for old age. They have been recipients of four hours homemaking each week for the past two years and John Vernon receives diabetic home-delivered meals.

Approximately one month before the upcoming interview, John was admitted to a local hospital for bi-lateral, below the knee amputations. He has been a troublesome patient and very unpopular with the staff. The hospital discharge planning staff strongly oppose returning John to his mother's house. They point out her age, heart condition and the two-story construction of her house as reasons for placing John in an accessible (and possibly supervised) site. John has admanantly

refused to discuss living alone in a handicapped apartment unit or in a nursing home. Despite being confined to a wheel chair, he wants to return to his mother's house. His sister, Susan, wants nothing to do with John and only goes to the hospital to accompany Mrs. Vernon.

Mrs. Vernon has agreed to meet with her case worker to try and work out after-care plans. She does not want her son to return, but she really is afraid of him. The day before this meeting John Vernon told his mother, "I'll get you, if you let them put me in a nursing home."

Case #10: For Assessment

Mrs. Carmella Santos is 85 years old and lives with her 89-year-old husband Paul and their daughter Ruth. Ruth was diagnosed as mildly mentally retarded in her childhood. She has never lived anywhere but with her parents. Both Mr. and Mrs. Santos are proud that their daughter was never institutionalized. Paul Santos is a retired butcher with emphysema and a recent history of three mild strokes. He speaks in a whisper and often has alarming coughing spells. The visiting nurse once described Mrs. Santos as being on the verge of falling asleep after a lifetime of weariness.

The Santos household receives twelve hours of home-care service each week. Both the homemaker and case manager have urged that Ruth Santos take more responsibility in caring for her parents. Despite their suggestions, however, Ruth seems established in her dependent, child-like role. She has given no indication of any desire to act more independently. Mrs. Santos wearily says, "I'd rather cook for her than argue with her." Paul Santos has never been involved with his children. He tends to remain aloof from them except on formal occasions such as major holidays and weddings.

Several months ago Mrs. Santos' case manager, Rachel Matthews, noticed dark bruises on Mrs. Santos' arm. When asked about them, Mrs. Santos said that she really couldn't remember but that she thought she might have fallen against her towel bar. Some weeks after that, Matthews received a phone call from the Santos' homemaker. The home aide said that she had seen Ruth punch Mrs. Santos when she dozed off during a conversation. The homemaker has tried to talk with her client about the problem but Mrs. Santos is very protective of Ruth. Mrs. Santos harbors an almost morbid fear that Ruth "might be put away and get pregnant."

The other Santos child is a son, Richard, who lives in Palo Alto. He has made no secret of his desire to institutionalize Ruth so that his mother "can finally rest." Mrs. Santos has begged her homemaker never to mention the bruises to Richard. The homemaker initially agreed to keep Mrs. Santos' confidence but changed her mind when the bruises continued to appear. Richard Santos is due to visit for his mother's birthday in two months and Mrs. Santos is fearful of his arrival. Recently, Paul Santos has been admitted to Catholic Memorial Hospital with complaints of chest pains.

Case #11: For Assessment

Mrs. Jessica Mattigan is an 81 year old Parkinson's victim who lives with her son George in a house which she owns. Mrs. Mattigan has been a client of Adult Protective Services for approximately one year. Because she has $10,000 in the bank, she has received limited service. A case worker did, however, assist with locating a geriatric day program which Mrs. Mattigan pays for and attends daily.

Even though Mrs. Mattigan uses a walker, she has frequently showed up at her day program bruised. At least once she fell so badly that stitches were required. Both the day program bus driver and the program nurse have expressed concern. The nurse has some questions about the client's ability to live independently without more skilled supervision. She has also noted that some of Mrs. Mattigan's bruises are on the face and forehead; less likely injury locations for a person who uses a walker.

Approximately one month ago son George lost his job as a dispatcher with a local trucking company. He claims that getting his mother ready for the day program caused him to be chronically tardy. The homemaker believes that he was fired for drinking on the job. Since his dismissal, Mrs. Mattigan's condition has deteriorated considerably. There are new bruises every two or three days and the nurse has questions about whether the client is getting her medication on schedule in the correct amounts. Further, Mrs. Mattigan has unaccountable outbursts of weeping.

The case worker has raised the issue of nursing home placement. Mrs. Mattigan is inclined towards it. George opposes it. He wants to remove his mother from the day program and care for her at home. George maintains that since he is not working it is foolish to "waste

money on the day program." Neither the program nurse nor the caseworker believe George is able to care for his mother. Regardless of their objections, though, George has threatened to seek guardianship of his mother in order to stop placement.

Despite Mrs. Mattigan's general assent to nursing home placement, her son's opposition clearly troubles her. Thinking that George's opposition stems in part from his fear that his inheritance might be consumed to pay nursing home costs, the caseworker attempts to explain the Medicaid rules. George Mattigan interrupts by saying, "You cannot tell me about rules and laws and what they mean." His refrain is, "I want my mother to stay at home with me. I can take care of her."

Case #12-15: Profiles Taken From Court Records

#12

After a divorce, Laura Webly, a middle-aged woman, moves in with her parents. The parents accept her presence and life settles into a fairly normal pattern. Shortly after her arrival, the parents go away for a few weeks of hard-earned vacation. They call back once a week to make sure everything is fine. On their return they find that Laura has systematically looted the home, selling everything of value. Their safe deposit box is empty. Laura has fled with the car.

#13

Marie, an 84-year-old woman, came home from a hospital after hip surgery. A next-door neighbor was made conservator for Marie. The conservator prohibited Marie's banker, lawyer, and friends from seeing her. There was evidence that mail and messages intended for Marie never reached her. The conservator also refused access to visiting nurses.

After receiving complaints from Marie's banker and lawyer, a superior court judge ordered a city police officer to accompany a mental health caseworker into the home. After seeing the court order, the conservator opened the home. Marie was interviewed extensively. Her main complaint was that her next-door neighbor/conservator was attempting to "shut me away." She trusted the conservator but could not understand her mania for secrecy.

After two subsequent court appearances, Marie was placed temporarily in a nursing home and a new conservator was appointed. Marie was then placed back in her own home where she received in-home care and health visits arranged for by the mental health district. The neighbor did not cause further problems.

#14

Ellen, a developmentally disabled older adult, had inherited a trust from her parents. The trust was administered at the discretion of two trustees who had institutionalized Ellen in an adequate board and care facility.

After several years, authorities discovered that Ellen was receiving SSI while her savings account was in excess of $400,000. No portion of the $400,000 was being used to support Ellen.

The county social worker and a welfare investigator interviewed the trustees and found that the trustees were living on the interest derived from the account.

Ellen was taken out of the institution and placed in a small board and care facility shared by some of her friends. The savings account financed the move and her care. The case of embezzlement and welfare fraud against the trustees is still pending in criminal court.

#15

Roger, a middle-aged man, took care of his 70-year-old mother. They lived in his home - an apartment in a very good area of town. Roger had been declared his mother's guardian and he used her pension to care for her needs.

Several years after the mother moved in, Roger lost his job. He fired the housekeeper/attendant and began to care for his mother alone. The mother appeared periodically at a medical facility to be treated for abrasions on her face and mouth. On a visit to the home, a visiting nurse discovered the woman had broken an arm. Roger said he slipped while helping his mother from the table, causing her to fall. He said he was happy to care for his mother who, he said, had shown him "great affection" as a child.

The visiting nurse had the mother hospitalized and called in a court-appointed social worker. After interviewing the mother and

son for many hours, the worker created a trusting relationship with the mother. The client finally admitted abuse by her son and asked for help. She said that Roger, an intimidating person, believed he was doing a good job in caring for her but that he believed she needed frequent slapping as a form of "discipline."

The judge in the case called a court session and lifted the power of guardianship from Roger. The social worker called in various service providers and had the mother placed in a private nursing home.

Roger, even after intensive therapy, remained isolated. It was discovered that his mother had abused him as a child. His abuse of her had become a form of revenge. In the words of a court investigator, "he had unresolved hatred of his mother based on childhood events."

Case #16: From the Records of A Visiting Nurses Association

A visiting nurse was assigned to an older woman who suffered periodically from malnutrition and dehydration. Once inside the home, the nurse discovered that the caretaker son witheld food and water as a way of controlling his mother and making her acquiesce to his demands.

The abuse included deliberate inattention to the mother's personal hygiene. The nurse attempted to compensate by training the son to care for his mother.

Subsequently, the nurse got a call from a neighbor who had visited the old lady. According to the neighbor, the older woman's arm was "swelling." The nurse called in two physicians with a mobile X-ray machine. They discovered a broken arm. The nurse then went to the probate court and had the woman removed from the house to a nursing home.

CHAPTER 10

BUILDING COMMUNITY AWARENESS THROUGH PUBLIC EDUCATION

Elder abuse and neglect remain unrecognized problems in most areas. A well-organized public education effort can shape and inform the public's perception of these problems which in turn can strengthen efforts to establish treatment and prevention programs.

An organization or committee working in this area should consider using public education as part of its overall strategy.

As a first step, the group should appoint an education coordinator in charge of arranging for talk shows, contacting media representatives, writing public service announcements, etc. If another public education program in the community addresses elder abuse and neglect, the education coordinator should attempt to develop a joint strategy with those working in that program.

There are several possible short- and long-term goals for a public education campaign on elder abuse. They include:

- Providing basic information on the facts of abuse and neglect.
- Encouraging elder abuse victims and their families to seek help.
- Persuading service providers to develop a more effective protective service system.
- Publicizing the beneficial impact of multidisciplinary cooperation.
- Linking elderly abuse to other forms of family violence to generate comprehensive services for all forms of domestic violence.
- Sensitizing the community to the special problems of particularly old and/or disabled elders.
- Affirming the right of older people to basic forms of care.
- Educating reporters and media staffs about elder abuse and neglect and their impact on the community.

The education program will probably begin slowly. Some people working in the elderly abuse field may feel the program will drain valuable resources from direct care efforts. It is the task of the education coordinator to emphasize the critical role public education must play in any serious effort to address elder abuse and neglect. The coordinator can cite as an effective example the lengthy and vigorous education campaign that was necessary to convince society to confront the problem of child abuse.

Public Presentations

The education coordinator should consider arranging for experts to address concerned groups of citizens. A single expert can deliver a speech or several experts can offer comments and answer questions in a panel format.

Often, however, there will not be experts available to attend all the presentations the education coordinator can arrange. Members of the group can make the presentations themselves if properly prepared. This means the education coordinator should work with experts to prepare one or more basic speeches for delivery by group members. It is not necessary to be a thoroughgoing expert to discuss the basic problem of elder abuse and neglect intelligently. The speech plus this manual should enable group members to make effective presentations to citizen groups.

There are a few general guidelines to consider in preparing and presenting a talk on elder abuse and neglect.

- Approach leaders at senior centers, churches, service clubs, and business groups, and ask to speak at their meetings. Don't wait for community leaders to approach you.
- Have a member of the group you will address advise you on how to tailor your speech to the group's needs and activities.
- Advertise the speech in appropriate ways prior to the event.
- Make it simple. In discussing an issue for the first time, emphasize one or two key concepts. Develop those concepts and summarize. Use handouts or audiovisuals for emphasis.
- Assume that no one in the audience knows about the problem. This will prevent you from "turning off" potential listeners. Everyone who is interested in family violence can gain from a good presentation.
- Avoid criticizing service providers in remarks made to a general audience. Be positive in affirming the need for treatment and prevention.

Use of the Media

Abuse of the elderly is an emotional issue. Many professionals working with the elderly justifiably fear media exploitation of their clients who are interviewed by reporters. Yet the answer is not to shun the media. Rather, there is a need to explain the problem to reporters while keeping them from sensationalizing particular instances of neglect and abuse. The media can act as an advocate for the elderly and serve as an important public education resource.

In fact, the media will inevitably define the issue for the mass audience. It is therefore in the best interests of service providers, action committees, and other organized groups to stay in direct contact with local media representatives to help assure informed, responsible coverage. This can be accomplished in several ways. The education coordinator or other knowledgeable individual should approach local reporters with information, volunteer to give press briefings, and act as an on-call media source.

Most reporters are unaware that violence against elders exists in the home environment. Having been briefed, however, reporters will probably ask many questions and request further information. The education coordinator should be able to provide basic answers and to cite or distribute materials.

Reporters should also be invited to attend workshops or other discussions of elder abuse and neglect. During these sessions, information packets or press kits should be handed out. Kits should include:

- A short description of the problem.
- A few short anonymous case histories.
- A description of the local problem.
- An outline of proposed or actual response mechanisms.
- Plans for mobilization such as a legislative initiative.

If a workshop or speech is to be given by an authority on the subject, the education coordinator should contact the press and local radio and television stations to arrange interviews. Local talk shows can be an effective means of disseminating information.

Local stations and newspapers also carry public service announcements (PSAs) received from nonprofit groups. The coordinator should write a PSA to correspond to each lecture, workshop, or speech given on the problem of elder abuse, and also should send a press release to all media contacts whenever the group has something substantial to report. A typical PSA for TV or radio and an example of a press release are provided on the next two pages.

SAMPLE PUBLIC SERVICE ANNOUNCEMENT

20 Seconds

Public Service Announcement
Contact: Education Coordinator
(123) 456-7890

TO AIR 1/02/81

EACH DAY WE GET OLDER. AND AS WE APPROACH OLD AGE, OUR NEED FOR LOVE AND AFFECTION INCREASES. YET RESEARCH INDICATES THAT FAMILIES UNDER STRESS MAY ABUSE OR NEGLECT THEIR OLDER MEMBERS. THE COMMITTEE ON CARE FOR THE ELDERLY IS SPONSORING A FREE LECTURE ON HOW YOUR FAMILY CAN SUPPORT ITS OLDER ADULT. IT'S TONIGHT AT UNION HIGH SCHOOL, 7:30 P.M. COME AND HEAR WHAT YOU AND THE COMMUNITY CAN OFFER THE OLDER PERSON. FOR MORE INFORMATION, CONTACT THE COMMITTEE AT (123) 456-7890.

SAMPLE PRESS RELEASE

For Immediate Release
January 2, 1981
Press Contact:
Jane Doe
(123) 456-7890

The State Probate Court said today that it plans to implement a new Office of Court Investigators, which will be responsible for investigating complaints of abuse and neglect against elder citizens. The move is seen as a victory for the Committee on Care for the Elderly, which fought for a court-appointed authority to work with local law enforcement officials and care providers in the treatment and prevention of elderly abuse.

PART V:
OREGON LAW AND RESOURCES

CHAPTER 11

LEGAL AND SOCIAL SERVICE REMEDIES IN OREGON

The State of Oregon has established a framework of laws and social services to address the needs of those persons who require assistance in managing their personal or financial affairs. For elderly persons who are the victims of abuse, either physical, financial or psychological, these "protective services" laws can be utilized to provide a partial solution to the abuse. The Oregon model is currently limited by both the nature of the applicable protective services statutes and the lack of adequate alternative resources in many Oregon communities.

Available Protective Services

Protective Services, as the term is used by professionals who work with the elderly, means a wide range of helping arrangements from social and health services to legal proceedings. An older person may need only a minimum of assistance such as home-delivered meals or housekeeper services in order to live in a dignified and comfortable way. Unfortunately, most often, especially among the elderly poor, the only adult protective services looked to are the most drastic ones: guardianship, conservatorship, and civil commitment.

Guardianships

Oregon law provides for the appointment of a guardian if a person is found to be incapacitated. A finding of incapacity must be based upon a court determination that a person is unable, without assistance, to properly manage or take care of his/her personal affairs and the appointment is necessary or desirable as a means of providing continuing care and supervision O.R.S. §§126.003(4), 126.107.

The court is required to appoint the most suitable qualified person who is willing to serve as a guardian. O.R.S.§126.035. In determining who to appoint as guardian, the court will give preference to a person requested in a written document prepared by the incapacitated person while competent and then to persons related by blood or marriage.

The court may appoint a temporary guardian for a limited duration. Such a guardian may replace a previously appointed guardian who is ineffective. A temporary guardian may be appointed with or without notice and may be removed at any time. O.R.S. §126.133.

A person subject to a guardianship hearing has the right to receive notice of the pending hearing, O.R.S. §126.007. S/he may be examined by a physician with a written report submitted to the court, O.R.S. §126.103(3). The court may also appoint a "visitor" to interview the person and report to the court on his/her condition, O.R.S. §126.103(4).

Any person interested in the incapacitated person's welfare or the incapacitated person may petition for the appointment of a guardian. O.R.S. §126.103(1). A public guardian may also petition for such an appointment. O.R.S. §126.925(1).

At the hearing the person alleged to be incapacitated may be present, has a right to his/her own counsel (but not to have counsel appointed), to present evidence, to cross-examine witnessed through counsel, and to request a closed hearing. O.R.S. §126.103(5). The court may appoint an attorney to represent the person (O.R.S. §126.103(2)), but this is rarely done.

The powers of a guardian are quite broad. The relationship of the guardian to ward is basically that of parent to child. The guardian determines the residence of the ward, O.R.S. §126.137(1) and may authorize medical or other professional treatment for the ward, O.R.S. § 126.137(1)(d). The guardian has a duty to act as a fiduciary with respect to the ward's finances and, if there is a conservator, to provide an accounting to him/her. O.R.S. §126.137(2).

There is no automatic review of a guardianship, although a temporary guardianship lasts a maximum of 6 months. O.R.S. §126.070(3). The ward or any other person may petition to have the court review the appointment of the guardian. O.R.S. §126.123(3).

The guardianship may be terminated by the death of the guardian or the ward, by court order, or by removal or resignation of the guardian. O.R.S. §126.117, §126.123.

By statute any county court or county commission may create an office of public guardian. O.R.S. §126.905. Only two such offices exist in Oregon. Multnomah County has an office of public guardian with two full time guardians plus support staff. Jackson County contracts with a private attorney to act as public guardian on a part-time basis. A public guardian is appointed only for persons who do not have relatives or friends willing or able to serve as guardian. O.R.S. §126.905(1).

Conservatorships

The Oregon statutes provide for the appointment of a "conservator" of a person's estate and affairs if a court finds that person is unable to manage his/her property and affairs effectively because of problems such as mental illness, mental deficiency, physical illness or disability, age, chronic drug use or chronic intoxication; and the person's property will be wasted and/or dissipated without proper management; or the person's funds are needed to support him/her or those entitled to his/her support. O.R.S.§126.157. The person for whom a conservator is appointed is called a "protected person" or "conservatee."

An individual or corporation may act as a conservator. O.R.S.§126.233. Preference is given to a spouse, adult child, relative or parent or someone nominated by a relative, or to a conservator or fiduciary in another state where the protected person resides. O.R.S.§126.333(2). A court may strictly limit the terms and the nature of the conservator's duties. O.R.S.§126.343. As with guardianship hearings, a court must provide notice to the person subject to the conservatorship hearing and may order him/her examined by a physician or court appointed visitor in order to assist the court's findings. O.R.S.§126.187.

The person to be "protected" may petition for the appointment of a conservator as well as any person interested in the estate of the person to be protected or any person who would be adversely affected by lack of effective management of the person's property. O.R.S.§126.183(1). At the court hearing, the person has a right to bring his/her own attorney but not to an attorney appointed and paid by the court. O.R.S.§126.197.

The powers of a conservator include control over most financial affairs of the protected person. O.R.S.§126.313. Title to property is maintained in the protected person's name and does not transfer to the conservator. O.R.S.§126.193. The protected person retains, if competent, most of the rights of a competent individual other than managing his/her estate as limited by the conservatorship. O.R.S.§126.223.

The conservator has the duty to use the protected assets to pay for the support, education, care or other benefits of the protected person and dependants. O.R.S. §126.317. The conservator must file an inventory of the person's estate, O.R.S. §126.277, and provide an accounting to the court (usually on an annual basis), O.R.S. §126.283, and to the protected person. O.R.S. §126.287. There is no automatic review of the need for the conservatorship. It may be removed for

the same reasons as a guardianship; death of conservator or conservatee, resignation of conservator or removal of conservator by the court. O.R.S. §126.267.

The public guardians, where they exist in Oregon, can act as conservators.

Civil Commitment

Civil commitment, a drastic measure in the spectrum of protective services, was not intended to address the issue of elderly abuse. Yet elderly persons, especially those who live alone and have been neglected or subjected to emotional abuse, may deteriorate to the point of perceived or actual mental illness and be subject to the commitment process.

Civil commitment requires a court to find that:

1. The person is suffering from a mental disorder; and

2. Because of that mental disorder, s/he is either dangerous to her/himself or to others or unable to provide for his/her basic personal needs and is not receiving such care as is necessary for personal health or safety. O.R.S. §426.005(2).

The commitment procedure is as follows. An investigation into mental illness begins with notification from the community mental health center program director to the probate court or circuit court. Any two persons including county health officials, magistrates, or police officers may initiate the commitment proceeding by submitting affidavits to the court alleging that a person is mentally ill. The court will then order an investigation by the county mental health department into the allegations. That department then makes a recommendation to the court whether or not there is probable cause to conduct a hearing. O.R.S. §436.070(1). If the court finds there is probable cause, based on the affidavits and the investigation, it may order the alleged mentally ill person to appear for a hearing. The court may order a person detained prior to the hearing if it finds an emergency exists. The hearing must be held within 5 days of the initiation of the proceeding, although it may be postponed by the court for up to an additional 72 hours. O.R.S. §426.200.

At the hearing the alleged mentally ill person has a right to an attorney. If s/he cannot afford one, the court will appoint one. O.R.S.§422.070(5). The hearing need not be held in court; it may be at a hospital or person's residence or other convenient location. There will be two court appointed medical examiners to assist the court in its finding of mental illness. If the individual requests it, a third examiner of the person's choice will be appointed by the court O.R.S.§426.110. If, after the hearing, the person is found to be mentally ill, the court has three options:

- Treatment of the person on a voluntary basis. The court will usually order this if all of the examining physicians agree it is appropriate. Rarely will there by a statutory finding of mental illness where the physicians agree to voluntary treatment.

- Conditional release to the care and custody of a guardian, friend, or relative. The individual accepting custody must request the court to allow this arrangement and provide assurances that s/he has the ability to care for the person. This type of placement can last for up to 180 days.

- Commitment of the individual to the State Mental Health Division when the court finds voluntary or conditional treatment "not in the best interests of the mentally ill person." The commitment is for a 180 day period. The state must request a new hearing after 180 days if it believes commitment is still appropriate and necessary. Commitment to the state may result in confinement in the Oregon State Hospital in Salem, Dammasch State Hospital in Wilsonville, or Eastern Oregon State Hospital in Pendleton. An elderly person committed to the State Mental Health Division is rarely sent to a mental hospital. The Division's policy has been to have the person examined at a local hospital and then to place him/her in a nursing home for the duration of the commitment.

Civil commitment does not involve a finding of incompetence. Oregon law is relatively advanced in making a clear distinction between standards for commitment (dangerous to self or others or inability to care for one's own basic needs) and the standard for incompetency (inability to manage one's affairs). No one is deemed incompetent by commitment to a state mental health facility unless the court makes a separate and distinct finding on this point. This is why committed individuals retain rights including, among others. the right to vote, contract, and buy and sell property. See O.R.S.§426.385.

Other Protective Arrangements

Two alternatives to guardianships and conservatorships exist for older persons unable to manage their own affairs, whether or not they have been declared legally incompetent. The first, a durable power of attorney, is a flexible solution which can be tailored to fit the needs of a specific situation. The second, a representative payeeship, is available in limited situations to handle government benefit payments.

Power of Attorney

This is simply a transfer of power from the individual to someone who may act on his or her behalf. A power of attorney may be limited to a specific act, such as selling a home, or may convey a wide range of authority. It consists of a written document defining the authority granted and its duration. The document must be notarized. It need not be recorded unless real property transactions are involved. No witnesses are required. The power may be revoked at any time. Anyone can prepare a power of attorney although it is advisable to consult a lawyer.

A power of attorney is particularly appropriate for older people confined to nursing homes or their own homes who do not have the mobility or desire to handle their own affairs.

A durable power of attorney differs significantly from a general power of attorney in that a general power of attorney is automatically extinguished when the person who transferred the authority becomes incompetent but the durable power of attorney may become effective or continue in effect or add new powers after a disabling condition occurs to the person who transferred the authority. Thus, the durable power of attorney allows a competent person to plan who and how his/her estate should be handled in the event s/he becomes disabled. A general power of attorney can be made a durable power of attorney by including in the original document a statement that "this power of attorney shall remain in effect upon the disability of the principal."

Representative Payees

Social Security and Supplemental Security Income and Veteran's Administration payments may be made to someone other than the beneficiary if the beneficiary is institutionalized or unlikely to use the money properly. There is no requirement that the beneficiary be found incompetent. A beneficiary or interested party must submit a statement asking that benefits be paid to someone else because the beneficiary is not capable of caring for them him/herself. The statement may specify who the representative payee is to be or the Social Security Administration or Veteran's

Administration may appoint someone of its own choosing. Preference in appointment is given to a spouse, relative or guardian, but a friend, public agency or an institution may also be named. Complaints about the propriety of appointing a representative payee for Social Security payments should be made to the Social Security Administration whose actions may be appealed in an administrative hearing. The Social Security Administration also is the proper forum to complain about the representative's handling of the beneficiary's funds.

Joint Bank Accounts

The simplest way to handle financial matters is a joint bank account. The problem here is that there are no safeguards to prevent the other joint tenant in the bank account from diverting the assets for his/her own use. Joint bank accounts therefore are recommended only when the elder person can fully trust the other joint tenant.

Commentary on the Remedies Available

The remedies available within Oregon's statutory scheme of protective services for elder abuse are limited. In some cases the legal "remedies" may contribute to the abuse.

The current framework for guardianships in Oregon is replete with problems. The public guardian in Multnomah County is understaffed and therefore has difficulty providing the appropriate level of personal care and supervision for its wards. Throughout the state it is very difficult finding people to act as guardians. If a person has an excess of $50,000 in assets, it is ordinarily possible to get a bank or a trust company to serve as a conservator but these institutions will not serve as guardians. There is currently a significant effort being made to create non-profit local corporations that would recruit, train, and supervise volunteer guardians. The idea is that the corporation would then assign volunteers or teams of volunteers to handle necessary care of the person. Washington County has made significant progress in this regard and hopes to have a corporation functioning by the middle of 1981.*

The procedures for establishing guardianship in Oregon have serious due process problems. If a notice of a pending hearing is sent to a person subject to the hearing, and no objection is received, the court may not even schedule a hearing. The manner of serving the

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* Anyone interested in this project should contact the Washington County Area Agency on Aging, or the State Office of Elderly Affairs - Legal Service Developer for the Elderly, Vince Salvi: Institute on Aging, Portland State University, P.O. Box 751, Portland, Oregon 92707. (503) 229-3952.

notice is defective in that it does not provide for the giving of notice in such a way as to make it likely that it will actually be received. The fact is that many elderly people who are the subject of a guardianship proceeding reside in an institution. A notice sent to this institution is sometimes just filed in the resident's chart. There is also no provision for a court appointed attorney in a guardianship proceeding.

At the very least there should be a mandatory hearing and a person appointed to represent the interests of the person subject to the hearing. That representative might be a lay person acting as a guardian or an attorney. The likelihood of a more in-depth review by the court of both the need for guardianship and available alternatives increases substantially if an advocate is present on behalf of the individual.

In addition, the law should be changed to provide for a mandatory periodic review of the need for, and activities of, a guardian. At present there is no mandated review unelss there is a petition to the court by an interested party. As with guardianships, the best way to actually protect the interests of an individual subject to a conservatorship is to have an advocate. These advocates should petition the courts for yearly accountings from the conservator.

Civil commitment is frequently inappropriately used as a solution in elder abuse cases. The only solution to this problem is the establishment of more community-based care facilities and outreach services which would identify those in need and provide them support. Elders subjected to civil committment and guardianship proceedings are most often those without family or community support systems.

Oregon Adult Abuse Prevention Act (O.R.S.§107.700 et seq.)

The Adult Abuse Prevention Act currently in effect ir Oregon allows a person claiming to be abused by a "family or household member" (limited by definition in the Statute to spouses, former spouses, persons cohabitating with each other or who cohabitated with each other within the prior year) to obtain an ex parte temporary restraining order from the circuit court. The temporary order, effective until a hearing can be held on the matter, is aimed at bringing about a cessation of abuse and may prohibit the alleged abuser from doing acts such as hitting, shouting or even entering the residence.

The police will not intervene in cases of domestic adult abuse until and unless a valid restraining order is issued and then violated. Violation of such an order can result in a finding of civil contempt for which the offender may be jailed or fined.

Pending Legislative Reform

A number of bills have been introduced into the 1981 Oregon Legislature which would affect the availability of protective services to abused elders as well as other disabled persons.

Guardianships

A bill primarily the work of the Oregon Association for Retarded Citizens would:

- Mandate that there be someone to represent all persons subject to a guardianship hearing (the representative need not be an attorney);
- Mandate a hearing in all guardianship proceedings;
- Place the burden of proof on the petitioner to show the need for the guardianship;
- Clarify the court's authority to appoint limited guardians;
- Mandate court reviews of all guardianships;
- Clarify state law to allow for corporations acting as guardians.

Domestic Violence

A legislative statement has been proposed to:

- Expand the scope of Oregon's Abuse Prevention Act to include more victims of domestic violence, including but not limited to, elderly victims abused by relatives other than spouses or by unrelated persons with whom such persons may be residing;
- Expand the scope of relief available in order to provide realistic remedies;
- Create a uniform statewide procedure for Abuse Prevention Act proceedings in order to eliminate confusion caused by a wide diversity of local rules;
- Facilitate public education concerning the Act;
- Enable victims of abuse to obtain relief without the assistance of a lawyer;

- Make law enforcement more effective by removing the statutory provision allowing police to refrain from arresting the abuser if the victim objects and requiring police to hand to victims and to read aloud a written statement of legal rights and remedies;

- Make the violation of an Abuse Prevention Act restraining order a crime;

- Protect victims of violence by requiring that provisions of Abuse Prevention Act restraining orders be incorporated into pretrial release agreements.

- Conduct research into the frequency and seriousness of domestic violence and monitor effectiveness of legislative remedies by requiring law enforcement record-keeping systems to maintain statistics on domestic violence.

A Proposal for Future Legislation

Although the legislation proposed in the 1981 Oregon Legislature is a significant improvement in addressing issues of domestic abuse in general and elder abuse in particular, it does not go far enough. A significant number of abused elderly may never come to the attention of law enforcement agencies. Home health providers, homemakers, senior outreach workers, clergy, and others may have frequent contact with a person they suspect to suffer abuse. A mandatory abuse reporting act, similar to the one outlined in Chapter 8 of this manual, is the next step Oregon must take to address this issue in its broadest terms.

Advocacy Resources

Legal Services

Almost every county in Oregon has a legal aid or legal services office. These offices represent clients who are low income or who fit case priorities. Few of these offices in the past have addressed the issue of elder abuse, although many have prioritized domestic violence. It is the therefore likely that they would act to obtain restraining orders or other emergency procedures to protect an abused elder.

If a client is not low income, a private attorney can be utilized to advocate on behalf of the abused victim. The best way to locate a good private attorney is to talk to people in the community and get their recommendations as to the competence and concern of members of the private bar. If there are no local contacts through which to seek a referral, the Oregon State Bar Association maintains a referral list for each area of the state. The toll-free number is located in the yellow pages of the phone book.

Area Agency on Aging

Oftentimes an attorney may not be available to assist an elder abuse victim, in which case there is a statewide advocacy network of lay people available to act. The local Area Agency on Aging, which can be located through the State Office of Elderly Affairs at the toll-free number 1-800-452-7813, can help find an advocate for the abused elder.

Supportive Social Services

Law Enforcement Agencies

Police and sheriff departments are mandated to do crisis intervention. Unfortunately, few arrests of abusers are made until a restraining order has been issued by a court and the police have probable cause to believe there has been a violation of the restraining order O.R.S. §107.715 and §133.310. Proposed legislation to remove the restriction on police to restrain from arresting the abuser if the victim objects, if passed, would constitute a significant step forward.

Adult and Family Services Division

Oregon's Adult and Family Services Division (AFS) has the statutory authorization to provide protective services to any individual, regardless of eligibility for public benefits provided by AFS. O.R.S. §411.116. By statute, O.R.S.§§411.010, 411.060, and 411.116, the Adult and Family Services Division is limited to providing only eight specific services as delineated in the Oregon Administrative Rules, §461-11-000. According to this regulation, AFS is authorized to:

- Identify such adults that need assistance and who have no one willing or able to assist them responsibly;
- Provide prompt response and investigation upon request of adults at risk or other persons acting on their behalf;
- Diagnose the individual's situation and service needs;
- Provide counseling to such adults, their families, other responsible person(s), or to surrogates such as representative payees;
- Assist in or arrange for appropriate alternative living arrangements in the community or in an institution;
- Assist in the location of medical care, legal services, and other resources in the community;

- Assist in or arrange for guardianship, commitment, or other protective placement as necessary;

- Provide advocacy to assure receipt of rights and entitlements due to adults at risk.

In giving this responsibility to the Adult and Family Services Division, the Oregon legislature failed to provide any additional funding to accompany it. The result is that some district offices take on this mandate with a higher degree of responsibility than others. At a minimum, the local AFS office, upon receipt of a report that a person is in need of protective services, should investigate the case. If the person is AFS-eligible and in need of protective services, the case worker must attempt an appropriate referral.

The local AFS office can provide emergency financial assistance, counseling, adult foster care, and other services to help eligible elderly victims. It can also act to provide referrals for those not eligible for its services because of their income level.

Mental Health Services

Community mental health services are available throughout the State of Oregon to provide crisis counseling, family outreach, individual therapy, and other services. Due to budget limitations, Oregon's commitment to serve the mental health needs of the elderly is, unfortunately, not high. Statistically, 20% of the people served in the community should be the elderly, but in fact, only about 6% are actually served. Some local offices are refusing to serve the elderly because their priority has been shifted to services to former mental hospital patients. With respect to the needs of the elderly abused, this policy should be completely revamped. Both the abused and the abusers are in need of supportive counseling and hopes of addressing the abuse issue are diminished without essential support services from community mental health agencies.

Office of Elderly Affairs/Area Agencies on Aging

The Office of Elderly Affairs provides federal Older Americans Act funds to the area agencies for various support services; transportation, nutrition, limited legal services, information and referral. These services are not specific protective services, but are generic services offered to persons with a full range of needs.

The Area Agencies on Aging also provide "in-home supportive services"

through ε state funded program, Oregon Project Independence. The services authorized are; chore services (household cleaning, repair, yard work), home health care, homemaker, housekeeper, escort services, and personal care. Again, these are not specific protective services, but are designed to provide support for the elderly in their homes.

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