

Innovations Assessment of the Elder Abuse Forensic Center of Orange County, California

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Overview (Executive Summary)

The Elder Abuse Forensic Center of Orange County, CA (hereinafter referred to as “the Center”) was launched in May of 2003, and has changed the way elder abuse cases are investigated and prosecuted in this jurisdiction. The center implements a collaborative intervention and investigation process involving ten collaborative agencies that are co-located one afternoon per week at the Adult Protective Services (APS) county headquarters. This co-location of representatives from the UCI College of Medicine’s Geriatrics Program, APS, the District Attorney’s Office, Sherriff’s Department, Public Administrator/Public Guardian, Community Services Programs, Long Term Care Ombudsman, Older Adult Services, and Human Options, enables these professionals to readily confer and communicate with each other regarding new and ongoing cases that require a collaborative response. Elder abuse cases are often complicated, as a single case may exhibit multiple types of abuse (for instance, co-morbidity of physical and financial abuse, or sexual abuse and neglect), and pose challenges regarding the medical or cognitive condition and needs of the victim. The Center’s central concept is the importance of unfettered collaboration of the various professionals to enable disparate systems (medical, legal, and social services) to effectively and comprehensively identify cases of elder abuse, facilitate prosecution where appropriate, and identify the appropriate legal course of action and service provision for these cases.

What do we know about projects like this? (In what way is it innovative? Has it been tried before? If it’s such a good idea, why aren’t others doing it?)

The multidisciplinary collaboration response model has been touted as the optimal method of responding to a myriad of under-reported crimes, such as intimate partner violence, sexual violence, child abuse, and elder abuse. For instance, the Duluth model is based upon coordination of the response of the many agencies and practitioners who respond to domestic violence cases in a community, and has been replicated across the country.¹ The U.S. Department of Justice has endorsed the Sexual Assault Response Team (SART) concept as the optimal way to coordinate immediate interventions and services in sexual assault cases.² Research findings on the effectiveness of the multidisciplinary response model are lacking, are limited to a small number of studies and are dominated by process-oriented evaluations. However, the evidence that exists supports the thesis that multidisciplinary intimate partner violence intervention models provides better services for victims and their children, more awareness of domestic violence issues by the criminal justice system, and a high level of cooperation and

¹ <http://www.duluth-model.org/>. Accessed January 23, 2007

² USDOJ Office on Violence Against Women. *A National Protocol for Sexual Assault Medical Forensic Examinations*, September 2004.

collaboration among system actors³. In addition, Nugent et al. found that SART interventions significantly increase the likelihood that charges will be filed in sexual assault cases.⁴ In addition, domestic violence and child abuse fatality review teams have been anecdotally cited as having a positive impact on improving systems' responses to the victims of these forms of abuse, and have been operating for decades.

In comparison with the sexual violence, domestic violence and child maltreatment fields, the elder mistreatment field has less experience with the multidisciplinary model. However, community collaboration efforts are playing an increasingly important role in improving system response to crimes against seniors. In the past decade, a handful of jurisdictions established special multidisciplinary teams that include professionals from the law enforcement, social service, medical, and other communities to collaborate on difficult cases that require multiple types of interventions, and to identify system improvement needs through systematic case reviews.⁵ Financial Abuse Specialist Teams (FASTs), for instance, focus on fiduciary abuse and may involve members with law enforcement, banking/accounting, and legal guardianship/conservator expertise. Fatality review teams involve different professionals from law enforcement, social services, and medicine, and examine deaths that resulted (or may have resulted) from elder abuse to determine whether systemic changes are possible and could prevent similar deaths in the future. Both concepts are in their nascent stages in the elder abuse field, and no rigorous outcome evaluation of either model has been done to date.⁶ Besides Orange County, the only other jurisdiction that has established a similar multidisciplinary structure and substantive approach to elder abuse cases is Houston, TX, which established the Texas Elder Abuse and Mistreatment (TEAM) Institute in 1998. However, the TEAM Institute has not incorporated prosecutors into its operations as fully as has the Center. In spite of this lack of evaluation data, the elder abuse field views the multidisciplinary model as a key strategy to identifying systemic problems and implementing targeted interventions in individual elder mistreatment cases.

What are the key elements of projects like this? (What's the model's logic? Why would we expect it to work?)

Widespread anecdotal and limited research information indicates that elder abuse cases are generally undetected, ineffectively investigated, and extremely difficult to prosecute successfully. The National Elder Abuse Study found that more than 500,000 older adults in the United States were abused, neglected, and/or experienced self-neglect in 1996.⁷ The study also estimated that almost 80% of the cases of elder abuse, neglect, and/or self-neglect go unreported to authorities. A recently concluded NIJ study found that older adults are susceptible "to events such as falls and adverse reactions to medications that

³ Uchida et al. *Evaluating a Multi-Disciplinary Response to Domestic Violence: The DVERT Program in Colorado Springs*. NIJ Final Report, August 2001.

⁴ M. Elaine Nugent-Borakove ; Patricia Fanflik ; David Troutman ; Nicole Johnson ; Ann Burgess ; Annie Lewis O'Connor. *Testing the Efficacy of SANE/SART Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?* NIJ Final Report NCJRS No. 214252

⁵ National Research Council. *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America*.131-132.

⁶ Ibid.

⁷ Lachs MS et al. *The Mortality of Elder Mistreatment*, JAMA 1998; 280 (5): 428-432.

may lead to injury.... [and] to developing conditions that result in malnutrition and cognitive impairment... [and such events and conditions] can potentially mimic or mask markers of abuse or neglect.” This in turn may greatly inhibit elder abuse detection and investigation efforts.⁸

In addition to the fact that this crime is believed to be grossly underreported and unrecognized due to the advanced age or illness of its victims, elder mistreatment often involves a constellation of forms of abuse which may require the complex response of a diverse group of actors from the law enforcement, financial guardianship, adult protective services, and the medical forensic communities to adequately investigate and adjudicate cases.⁹ Finally, the deficient state of knowledge of elder mistreatment, both in terms of unreliable estimates of how many people are victimized, as well as the poor state of forensic knowledge pertaining to markers of elder mistreatment, is a tremendous barrier to detecting and investigating these complicated crimes.

Due to the varied expertise, lack of data and fiscal resources, as well as the different social service, medical, and criminal justice systems required to comprehensively respond to crimes of elder abuse, the multidisciplinary collaborative model holds great promise. However, as previously stated, such multidisciplinary models are not commonly employed to respond to elder mistreatment. Often, law enforcement, social service agencies, and public guardianship officials do not interact on a daily basis, and in effect speak different languages and have different (and sometimes competing) priorities and definitions of what constitutes a good outcome in an elder abuse case. For instance, a police officer might believe that the optimal outcome of an elder neglect case is the arrest and conviction of the offender. In contrast, a social worker handling the same case may view the arrest, conviction, and confinement of the elder’s only caretaker as counterproductive to the victim’s well being, and might favor improving the caretaker’s capacity to provide appropriate care in the future. Negotiating a positive outcome using these two disparate perspectives requires more compromise and negotiation than most practitioners are able or have time in which to engage.

The collaborative process is not easily coordinated, achieved, or maintained, and these logistical barriers, professional language differences, and competing priorities may inhibit effective systemic response to elder mistreatment. A model that overcomes such barriers between relevant agencies and enables true collaboration and comprehensive response may profoundly affect the outcome of these cases. In its optimal form, collaboration “brings previously separated organizations into a new structure with full

⁸ Dyer et al., *Factors that Impact the Determination by Medical Examiners of Elder Mistreatment as a Cause of Death in Older People*. January 2007. NIJ Draft Final Report.

⁹ For instance, an older person suffers from a blood clotting disorder, and who is simultaneously victimized physically and financially, would require intervention from several actors in addition to adult protective services to effectively resolve their case. Such a case would optimally involve action from public officials who can freeze financial assets, law enforcement officers who can build a case for abuse and neglect charges based on solid evidence, as well as medical professionals who can distinguish the signs of abuse from effects of the victim’s blood ailment and assess ongoing medical requirements. Anecdotal information indicates that this is not the manner in which such a case would be approached in the majority of communities in the United States, if it were detected at all.

commitment to a common mission... [in which] resources are pooled or jointly secured, and the projects are shared.”¹⁰ Research literature on the subject of collaboration stresses the importance of: 1) establishing shared vision and defined goals; 2) trust; 3) a jointly developed structure and shared responsibility; 4) avenues of open and direct communication; and 5) mutual authority and accountability.¹¹ Each of these elements is challenging to achieve due to diverse system priorities, resources, and levels of commitment that individuals and agencies bring to the collaboration process. However, when collaboration so defined does occur, limited research suggests that the criminal justice system more effectively responds to pressing crime issues.¹²

What is the background/history of this specific project?

The Geriatrics Program at the University of California Irvine (UCI) established the Center in 2003 with funds provided by the Archstone Foundation, and claims it is the first effort of its kind. The Center’s mission statement is *to identify and promote the appropriate legal remedies for elder abuse through collaborative evaluation, consultation, education and research.*¹³ The elder forensics center handles ongoing cases of elder mistreatment and attempts to improve system response to elderly and disabled victims. California law identifies elder mistreatment as involving one or more of the following acts: physical, psychological, or financial abuse, neglect, abduction, abandonment, isolation or other treatment that results in physical harm or pain or mental suffering.¹⁴ The Center has enabled successful collaboration between diverse and, at times, seemingly disparate actors in the criminal justice, medical, fiduciary, and social services systems.

The Center began as “a bold collaborative experiment” that brought all system actors relevant to elder abuse cases together on a regular basis to review new and ongoing cases and share expertise. Dr. Laura Mosqueda is the founder of the Center, and was the main proponent of enhancing the multidisciplinary response to elder mistreatment in Orange County. While in private gerontology practice, Dr. Mosqueda worked with the County’s Adult Protective Services (APS) agency on a regular basis. Over time, she became very frustrated that often nothing would happen when elder abuse was reported to the authorities. As a result, Dr. Mosqueda organized a meeting in July 2002 that was attended by representatives of Orange County’s APS, Sheriff’s Department, District Attorney’s Office, Office of the Public Guardian, Victims’ Advocate Program, and the UCI Geriatrics Program. Invited agency participants agreed that:

- Abuse of vulnerable adults cannot be addressed without collaboration;
- Agencies wanted to collaborate; and
- Effective collaboration was not occurring because agencies were not able to “get

¹⁰ Downing, Myra. *Measuring Collaboration in Criminal Justice Problem Solving Projects*, p. 12, NCJ 213252; NIJ-Sponsored, June 2005.

¹¹ Ibid. p. 21.

¹² See *Reducing Gun Violence: The Boston Gun Project's Operation Ceasefire*, NCJRS No. 188741; *Violence Against Women and Family Violence: Developments in Research, Practice, and Policy*, 2004, Bonnie Fisher, ed. NCJRS No. 199701.

¹³ Mosqueda et. al. 2006 Final Report on Elder Abuse Forensic Center to the Archstone Foundation. p. 2.

¹⁴ Mosqueda, et al. Elder Abuse Forensic Center Evaluation application, 2004, p. 3

what they need from other agencies.”

The participants identified lack of communication, lack of time and resources, and lack of knowledge of the procedures, parameters, and perspectives of other agencies as the main obstacles to collaboration. The leaders of the diverse agencies who attended this meeting agreed to partner with UCI’s School of Medicine to create a team to break down these barriers and improve the community’s response to crimes against elderly and other vulnerable adults. Each agency leader designated an individual from their organization to work in a shared location twice per week and participate in two meetings per week to review ongoing cases and share expertise. In the initial stages of this relationship-building process, the group’s efforts primarily focused on learning each other’s vantage points and occupational culture in order to encourage and increase group cohesion.

The Center cites the following as its primary purposes:

- Prevention of and response to the abuse, neglect, and exploitation of at-risk older and disabled adults in the local community through the collaboration of professionals in law, medicine, and social services;
- Education of professionals who deal with the crime of elder abuse including law enforcement, the medical community, social services, the legal community, government officials, investigative agencies, academic institutions, and older adults and their families regarding effective prevention and prosecution;
- Advancement of awareness of elder abuse through research on the abuse and neglect of at-risk older and disabled adults; and
- Creation of a new standard for interventions that are effective in combating and preventing mistreatment of older adults.¹⁵

What are the key project elements? (A program overview: What’s involved? In what ways have they followed or modified the model described above?)

The operation of the Center is structured around achieving its goals of providing direct services and successfully adjudicating elder abuse cases through the collaborative process, providing training to those who deal with the crime of elder abuse, and raising awareness of elder/dependent adult abuse through research. To achieve these goals, ten objectives were established that guide the Center’s daily and strategic planning.

Objective One: Bring Together a Multidisciplinary Team of Professionals in Elder Abuse

The original plan for the Center called for it to be staffed by professionals from the following organizations twice per week:

- Sheriff’s Department
- Office of the District Attorney
- Geriatric Medicine
- Ombudsman
- Adult Protective Services

¹⁵ Mosqueda et. al. Elder Abuse Forensic Center Overview, p.1

- Public Guardian and Public Administrator
- Older Adult Mental Health Services
- Community Services Program's Victim's Advocate
- Human Option's Domestic Violence Program

According to team members, there has been “remarkable stability” regarding agency staffing of the team, and the Center has not lost any team members. Although the frequency of meetings has changed from twice to once per week, this change was made to better accommodate team members’ practical needs for flexible scheduling and more informal consultation opportunities with other members.

Objective Two: Work from a Shared Location

In order to achieve collaboration and encourage agencies to “get what they want” from each other, the team established a shared location structure from which the Center’s participant members would operate. Orange County and UCI entered into a rent-free lease agreement in 2003, which provides six computers, phone-equipped offices and a conference room within the County’s APS building. This co-location would ensure that the Center’s participants and the county’s APS professionals would interact regularly and have easy access to each other for relationship building and case consultation purposes. One challenge that emerged was that during this co-location period, Center participants did not have access to their respective agencies’ case record and communication data resources, which has not yet been resolved.

An APS official expressed concern that the shared space the agency currently provides may be eliminated to make room for increases in APS staffing. This is of real concern, as the co-location concept is viewed as “very necessary” and “central” to the Center’s functionality.

Objective Three: Provide Case Consultation

During the team meetings that were originally scheduled to occur twice per week, the Center received and reviewed 371 cases from APS, the Ombudsmen, law enforcement and the Office of the District Attorney. The objective of these case reviews was to provide guidance from the multidisciplinary team to the investigating agents on how to address the issues posed by each case and maximize chances of a positive outcome (whether through provision of services, protection of assets, prosecution of offenders, or a combination of some or all of these elements). As of December 31, 2005, the Center reported that 82% of these referrals were made by APS, a trend that has continued to the present time (confirmed in December, 2006). Efforts were made to increase referrals from law enforcement by providing officers with additional training, “selling” the Center’s services as a way to make investigations easier, and increasing personal contacts with officers who tend to receive elder abuse cases. Although APS referrals make up the bulk of the caseload the Center manages, stakeholders claim that law enforcement participation in the process has improved as a result of these efforts. Team members consistently reported that the Center performs team reviews of approximately two to three cases per week.

Objective Four: Provide In-Home Response

The Center reported that of the 371 cases that were referred by December 31, 2005, 141 of these cases required involvement of the Vulnerable Adult Specialist Team (VAST). The VAST is composed of medical (including gerontology expertise) and psychological experts who conduct in-home visits to vulnerable adults and provide medical, psychological and forensic assessments of vulnerable adults who come to the attention of authorities as possible victims of abuse. These assessments assist authorities in determining if abuse has occurred, the nature of said abuse, the competence of the victim, and a recommended course of action.

Objective Five: Multidisciplinary and Systematic Tracking and Follow-through with Cases

Most multidisciplinary teams engage in a one-time consultation with a particular case, and do not follow cases as they progress through the system. Originally, this was the case with the Center. However, team members eventually determined that it was valuable to follow up with cases after the initial consultation and provide ongoing input, so it created a case update system that tracks a case until it is resolved. This enables the agency that brought the case to the attention of the Center to receive ongoing consultation, and also enables the team to see how cases have progressed. The ability of the team to learn the outcome of its efforts reinforces members' commitment to the Center concept and the multidisciplinary process.

Objective Six: Provide Education and Training

The team has developed a multidisciplinary core curriculum for presentations about elder abuse investigations. The curriculum includes an introduction to the crime of elder abuse, perspectives from each agency actor (i.e., law enforcement, prosecutor, social services, etc.), an overview of the Center itself, and a detailed examination of the medical and psychological issues that elder abuse cases commonly present. The Center is also producing a replication guide in the form of a DVD for other jurisdictions that are interested in establishing an Elder Abuse Forensics Center.

Objective Seven: Provide Case and Program Consultation

The members of the Center have consulted on cases both within Orange County and outside of their immediate community. As of early 2006, the physicians had served as medical consultants to those pursuing elder abuse cases in 14 counties throughout California and four other states. The Center uses teleconsultation equipment to provide expert case input and to provide technical assistance to other jurisdictions that are interested in establishing multidisciplinary response mechanisms for elder abuse cases.

Objective Eight: Conduct Research on Elder Mistreatment

The Center is the site of ongoing elder abuse research, including several projects supported by NIJ. Thus far, the Center has produced data on geriatric bruising patterns, and is currently engaged in groundbreaking research on the subject of decubitous ulcer development (commonly referred to as bed sores).

Objective Nine: Disseminate Findings from the Elder Abuse Forensic Center

Members of the Center, and Dr. Mosqueda in particular, publish findings from both their practical experiences and ongoing research in a variety of practitioner and researcher oriented journals. Dr. Mosqueda also makes presentations all over the country on the subject of elder abuse, and has presented at such conferences as the NDAA's training conferences and statewide symposiums on elder abuse and neglect.

Objective Ten: Ensure the Continuation of the Elder Abuse Forensic Center

Program sustainability is always a concern in the multidisciplinary context, as fiscal resources, personnel, and political environments can change quickly and greatly influence the structure's ability to carry out its work effectively and maintain its focus on its original goals and objectives. The sustainability of the Center is aided by the complementary office space provided by Orange County, and a grant from the Archstone Foundation, which funded the Center until December 2005. At the present time, the Center exists under the auspices of the University's Center of Excellence in Elder Abuse, but there is a consistent need for additional funding in order to support the administrative responsibilities and participation of medical professionals in the team. The central role of the geriatric medical actors in the process is perhaps the most innovative aspect of the Center, and one that differentiates it from other multidisciplinary models. Nearly all of the Center members participate in Center activities as part of their agency role, but a stable source of funding is required to support the participation of the doctors and psychologists.

The collaborative partners agree that the Center has improved the County's response to elder mistreatment cases, has improved and increased the numbers of cases prosecuted, and has broken down communication barriers between actors. The Center is currently being replicated in Los Angeles and may soon be adopted by other jurisdictions, as indicated by requests for information about the Center from other jurisdictions (even some from outside the United States). Therefore, there is a need for process and evaluation data on this innovative program to aid and inform this replication process.

No rigorous process or outcome evaluations have been performed of the Center to date. A small study of Center members' perceptions of the model's effectiveness was performed in 2006. This study found that in 81% of the cases handled by the Center, members thought the cases were handled more effectively than they would have been without the Center's involvement. Reasons for this increase in effectiveness include: 1) the ability to have the District Attorney and law enforcement communicate more effectively in terms of evidence needed for case prosecution; 2) the increased capability to provide medical forensic evidence of abuse; and 3) better evidence collection procedures. In addition, the actors perceived that cases seen by the Center were more efficiently handled by system actors because of their increased ability to determine the client's mental capacity, to interface with collaborators and easily share information, to communicate with clients and/or their family members, and to determine early on whether a case required a criminal or civil remedy.

Output data regarding the impact of the Center on elder abuse cases in Orange County

indicate that prosecution of elder mistreatment has increased during the evolution of the Center. Pre-Center data on elder abuse prosecutions was not maintained, and therefore a pre-post comparison of elder abuse case prosecution in Orange County is not possible.

What are the size, characteristics, and eligibility criteria for target group?

In 2006, Orange County's APS agency received 5,650 elder abuse complaints. Although additional reports may come directly to law enforcement instead of APS, there are approximately twenty-five law enforcement jurisdictions in Orange County, and they do not specifically compile elder abuse data. The Ombudsman's office maintains data on the number of reports that come to ombudsmen (from nursing homes and residential facilities), but such data likely does not accurately reflect the incidence of abuse in licensed facilities in the County.

From 2003 to 2006, the Center received a total of 448 referrals. In 2005, the Center received a total of 108 referrals, with 89% coming from APS, 3% from the District Attorney, 3% from Law Enforcement, and 6% from the Ombudsman. In 2006, Center participants made 94 referrals, with 89% by APS, 5% by the District Attorney, 3% by Law Enforcement, and 2% by the Ombudsman. There were 702 VAST consultations between 2001 and 2006 (the VAST pre-existed the Center). There were 52 VAST consultations in 2005 and 57 in 2006.

Who gets excluded?

As has been previously discussed, elder mistreatment is an underreported and under-detected crime, so any study sample based upon reported cases would exhibit bias, as unreported cases would be excluded and could significantly differ from cases that are reported. In addition, not every APS social worker uses the Center as a resource or refers cases to the Center. There has been a deliberate effort to show the value of the center to all APS workers, but not all social workers work the same way, and many are still reluctant to use the Center in their daily practice. At times, this reluctance to engage the Center can involve a basic disinclination to speak in a group setting, which is a basic requirement of anyone using the Center's group consultation services. Therefore, the possibility of a case getting referred to the Center depends heavily on which caseworker is assigned to the case, and not necessarily the merits or characteristics of that case. The result is that not every case that could benefit from the Center's services is referred. Finally, not every case that is reported to law enforcement is "coded" as elder abuse. It may be coded as a robbery, an incidence of domestic violence, or another crime that is not statistically captured as an elder abuse crime, so these cases are excluded from the number of reports cited above.

Is entry voluntary?

Yes. Referral to the Center is a voluntary act on the part of the agency that receives an elder mistreatment report. As stated, this referral depends on the decision-making processes of the caseworker assigned to the case. Individual victims are not consulted prior to having their cases reviewed by the Center members.

What are the project's impact/outcome goals?

The overarching goal expressed by team members is twofold: to assist and protect seniors, and to “do the right thing” with perpetrators. Depending on the case, the team may push for criminal prosecution of a perpetrator, or take a very different approach should it determine that the “perpetrator” is actually an overwhelmed caretaker and the elderly person would be better served if this caretaker received help instead of punishment. As one law enforcement official stated, “Normally, for law enforcement, success is measured by the number of people who go to jail. That is not always the goal here. APS might be able to take the case and make a bad situation better, without involving us.”

At what stage of implementation is it?

The Center has been functioning since May of 2003, and is now fully operational and established among team members and in the community. While it has not received funding in over a year since the conclusion of the original Archstone Foundation Grant that supported its establishment, this has not halted or delayed the Center’s work. Instead, Dr. Mosqueda has found creative ways to financially and practically sustain the participation of the medical and administrative personnel from UCI. Other team members remain engaged and dedicated to the process, structure and case investigation advantages that the Center provides.

Is the project being implemented as described?

NIJ staff performed intensive interviews with all Center members to assess implementation fidelity, and subsequently compared the comments they provided. All members gave remarkably similar statements about the Center’s history, operation, and perceived benefits and weaknesses. In general, all members acknowledged that administrative changes have been made to make the Center function more efficiently (i.e., changing from two meetings per week to one, and having annual retreats to discuss strategic planning and strategy). All had similar levels of high enthusiasm for the Center’s approach to elder abuse cases, and all stated that they were able to perform their jobs more efficiently or effectively as a result of their participation in the Center.

Victim Advocates stated that their affiliation with the Center gave them more credibility in dealing with elder abuse cases. While advocates tend to have significant credibility within the child abuse and intimate partner violence fields, this is not the case in the elder abuse area, as it is still very new and unfamiliar to the majority of advocates. In addition, they stated that the Center has enabled them to learn the language of and to communicate with other professional groups, such as law enforcement and prosecutors, much more effectively. Finally, the advocates recognized that there is a new willingness to “share the ball,” and to work collaboratively and view things from each other’s perspectives. The advocates also held the opinion that victims receive services much faster and more effectively from the advocates than they had prior to the inception of the Center, especially in terms of follow-up case management.

The official from the **Office of the Public Guardian** enthusiastically supports the Center, as it enables him to form the formal and informal professional relationships that are integral to his being able to detect and intervene in elder financial abuse cases. In

spite of laws permitting multidisciplinary team (MDT) members to share information with each other without violating victim/client/patient confidentiality, he found that people remained reluctant to openly share information due to privacy concerns. The Center helped to break down these artificial barriers. He also stated that the Center helped clarify each actor's capabilities in terms of responding to elder mistreatment cases. Law enforcement, APS workers or advocates would often want him to place an elderly person's assets into conservatorship to protect them from financial exploitation. However, the Public Guardian's role is to find alternatives to conservatorship and to use this authority as a last resort. Disagreements yielded opportunities for Center participants to educate each other on their respective authority, mission, perspective, and capabilities. Having this clear understanding enhanced their ability to respond both individually and as a team to elder mistreatment cases. There is a lingering frustration on the part of the Public Guardian, as well as other team members, that more cases are not investigated and prosecuted due to limited resources in spite of the Center's best efforts. Nonetheless, he expressed that they are able to respond to cases far more quickly and effectively than they had been able to do so before the Center was established.

The team member representing **Older Adult Mental Health Services** says that the positive results he sees from the work of the Center keeps him and his agency engaged in the process. In addition, there are few costs involved, as his time is paid for regardless of where he is physically doing his job. In fact, he believes that the increased communication enhances efficiency on the part of all participants to build elder abuse cases. He also credits the dynamic leadership of Dr. Mosqueda and Dr. Gibbs with sustaining the Center through political and interpersonal communication challenges among group members. The end result is that Center participants have been able to learn from each other and change the way they communicate and view each other's responsibilities. The Center's leadership has increased their own patience with the established system, and has learned how to achieve good outcomes for elder abuse victims within the confines of the County system while also questioning and productively pushing against those very confines. The Center fills a void in the response to elder abuse by providing the medical perspective, which until the Center was established, had been a missing or inadequate part of investigations in the County. In addition, having the UCI's Medical Center coordinate the Center is politically advantageous, as it has a "better pedigree" than a similar County-organized effort would have, and avoids the "big brother" stigma.

Members of **Law Enforcement** who are involved in the center are enthusiastic about its perceived effect on elder abuse investigations and prosecutions, as well as their ability to follow up on cases that would have normally fallen through the cracks in the system. There is a general feeling that they are "doing the right thing" with the Center's help. Law enforcement did not always have an easy role in the Center, as it was clear at the beginning that team members wanted the police to do more than was feasible. This continues to be a minor issue, as team members regularly claim that "the cops wouldn't do anything" in a particular case, but the situation is consistently improving. After building relationships and educating each other during the Center's meetings, other team members learned that law enforcement often cannot or should not be the answer to every

abuse case. As previously stated, law enforcement's success is commonly measured by the number of people who go to jail. For Center members, incarceration of the perpetrator is now not always the goal. In particular cases, APS can educate family members and provide the social services they and the vulnerable adult need and resolve the case without arrest. In cases of frail elders, the Center can provide a VAST assessment to attain or enhance needed medical services for the individual. Law enforcement has a better understanding and respect for why APS and the Office of the District Attorney make the decisions that they make in terms of prosecution. The law enforcement representatives feel that the Center saves them significant time, as a task that might have taken months to arrange prior to their involvement in the Center (such as a medical evaluation/consultation, or a freezing of financial assets) can be arranged and resolved in less than two hours through existing and ongoing relationships. The police are doing better quality work in a shorter amount of time, as the prosecutor can quickly and clearly impart his evidentiary needs and law enforcement can follow through with actions that meet those specific needs and build stronger cases. As a result of this increase in perceived effectiveness, however, law enforcement officers felt that they are investigating many more elder abuse cases (as many cases that would have "fallen by the wayside" no longer do), so cost savings are not clear and their workloads are increasing. They also feel, however, that savings are reaped in terms of human lives and an increased quality of life of vulnerable adults in the County.

The **Medical/Gerontology Professionals** who organize the Center and participate on the VAST team are regarded by other team members as central to its effectiveness. The physicians believe the communication among actors has been greatly aided and improved by the establishment of the Center, and that the co-location model provides education and accessibility to all participants. The contact extends beyond the time participants reside at the Center, as the physicians will receive multiple emails and calls throughout the week about particular cases or requests to attend court hearings. In many cases, a medical consultation is needed, and they are hard to arrange unless there is an established relationship with a doctor with geriatric expertise. Most APS workers do not have direct access to medical personnel, and it is "amazing how much medical evaluation is necessary" in these cases. Not only do the physicians at the center perform evaluations in conjunction with elder abuse cases, but they also serve as a conduit for further medical interventions by referring the older person in question to a geriatrician for a complete medical assessment. The physicians feel that the ability of the entire group to consistently educate each other and to work together on these complex cases has improved response. This mutual education occurred as a result of efforts to surmount the cultural differences between the involved occupation groups, which include learning each other's languages, goals and expectations.

The physicians believe that the District Attorney's caseload has "skyrocketed," and that the prosecutor's office is more proficient in understanding what an elder abuse prosecution requires and the medical/forensic components that must be considered in these cases. As a result, the accessibility of physicians under the Center's model is a huge benefit to criminal justice actors and increases efficiency. Doctors are often unwilling to testify in court for a variety of reasons, so to have access to several who are

willing to participate and are proficient in providing court testimony is a tremendous advantage. While Dr. Mosqueda testifies more often, the other involved physicians do so two or three times per year in both preliminary hearings and jury trials.

The physicians also stated that the quality of cases that are presented at the Center's meeting has changed. At the beginning, the participating APS professionals would bring various cases forward for the Center's review "just to test the waters." Now, people referring cases are more likely to perform advanced investigations in order to gather more information on cases, and those that are now presented to the group are far more likely to benefit from a multidisciplinary consultation. The doctors informally confer with other group members to advise whether a case is "ripe" enough for presentation at a Center meeting.

The participating **Prosecutor** agrees with the physicians' assessment that the Center's processes have created higher quality elder abuse investigations and cases, and that he has been educated by the process. He also believes that the Center greatly enhances mutual communication between, and education of, all of the agencies. The defense bar and the judiciary have also exhibited signs of increased awareness of these cases, as they have acknowledged that the Office of the District Attorney is now very well prepared to prosecute them and that these cases should be taken very seriously. The prosecutor's elder abuse caseload has increased dramatically, as he has gone from carrying an average of ten cases to twenty-five or thirty cases at a time. The number of cases his office reviews for prosecution has tripled, and the number of cases for which they file charges has probably doubled. The District Attorneys Office is now taking more "edgy" cases that are not as assured of conviction because of the increased resources and input the Center provides, so the official conviction rate may not have changed significantly for this reason. However, he feels that he resolves his cases more favorably in terms of victim and perpetrator outcomes than he had prior to the creation of the Center.

With all of these indicators of success, the prosecutor's role in the Center has not been without conflict. Not every case that the Center refers to the prosecutor is criminal in nature, and adequate evidence of a criminal act is not always provided. In such cases, the prosecutor cannot prosecute, which is "not a popular decision." This can cause conflict, but the group has learned how to work through these disagreements. Overall, the prosecutor believes that the Center is a way to effectively leverage resources, in the sense that prosecutors and police have an open line of communication regarding the type of evidence that is required and what cases will actually progress through the system. Under such circumstances, police are less likely to drop an elder abuse case because they do not know how to approach it, pursue a case that has no chance of advancement, or waste valuable time chasing information that can be gathered from the Center's Tuesday meeting. In addition, time is of the essence in elder abuse cases due to a variety of factors, including the ability of witnesses to recall events, the collection physical evidence of abuse, and the simple fact that people of advanced age do not have years to wait for case resolution. The time the Center saves its actors because of the co-location model is an extremely important measure of its success.

In the opinion of the **Adult Protective Services** officials who participate in the Center, the structure has improved elder abuse response at both a local and national level. The Center's coordination and research efforts have "saved a lot of lives" in the community and "increased awareness" of elder abuse in the country. As it is a relatively new field for most social service workers, this cross-disciplinary and substantive education is crucial to addressing the problem successfully.

In spite of these positive statements, APS also acknowledges that the agency faces many remaining challenges to improving its response to elder abuse reports. There is a strong desire to improve response among APS workers, but obtaining adequate resources to accomplish this continues to challenge the agency. APS experienced record reports in 2005, but did not have the staff to optimally respond to this increase. This takes its toll on the APS staff, who become "really weary" as they tend to witness very difficult situations in the midst of increasing caseloads. Although reports have increased, it can be a challenge to morale without adequate resources to effect positive change.

While APS leadership acknowledges that the Center's core participants are cohesive, they also state that APS workers who make referrals and occasionally present cases at the weekly meeting feel like outsiders. When they receive criticism from the group, conflict, hurt feelings, and reluctance to present cases in the future may result, as these peripheral actors are not as familiar with the different languages used and communication styles exhibited by the Center's various participants. This has been APS' most significant challenge to participating in the Center process. However, the desire for positive case outcomes continues to bring them to the table and inspires them to work on these relationship issues. APS acknowledges that other group participants have powers that they do not, such as the ability obtain restraining orders, and this ability to accomplish good outcomes through improved coordination "keeps them coming back."

APS also acknowledges that this increased coordination yields cost savings, as improved response results in more elderly people staying in their own homes due to more accurate medical diagnoses provided by the Center's VAST team. To illustrate this point, there are occasions when an APS worker may determine that an elderly person is suffering from dementia, when in reality the person actually has a urinary tract infection or another medical ailment that is influencing behavior. Accurate diagnoses are key to providing appropriate remedies.

APS raised one significant challenge to sustainability that was not mentioned by other participants. The In Home Support Services (IHSS) section of APS has greatly increased in size recently, and the Agency's leadership is looking for more physical space to accommodate this program. APS has agreed to provide the Center with co-location space for as long as it is possible to do so, but this may interfere with their ability to maintain the current arrangement. APS leadership acknowledges that the co-location model is "great" and important to the success of the model. They also acknowledged the importance of APS' ready access to UCI's gerontologists, as it lends APS investigations additional credibility and the medical component that often proves crucial to positively resolving these cases. As of December 2006, the space issue remained unresolved.

What data systems exist that would facilitate evaluation?

The Center maintains its own MS ACCESS database. The overlap of the APS data with that of the Center is minimal, but there are some common elements. The Center's database shares some fields with the County's APS case database, including the findings for every allegation in each elder abuse case. In California, each allegation that meets the criteria for being investigated (and nearly all are investigated) is given a finding of confirmed, unfounded or inconclusive. Other fields that APS and the Center likely share for most cases are demographic information on the victim and the perpetrator, case plans, and field notes. However, the Center's database also captures case outcomes in other agencies, such as Office of the Public Guardian and the District Attorney's Office. Follow-up for this information is more opportunistic rather than a result of active solicitation of information from these agencies.

The APS case database is currently under revision, and will soon be web-based. The current database contains data culled from the "AIS form" that APS workers use during investigations, and this includes information on each subject's cognitive functioning level, medications used, collateral contact with APS, and case information. APS recognizes that there is some inconsistency regarding how individual social workers identify different forms of abuse, and this could affect the accuracy of the data elements.

One year, the Center surveyed the collaborators as to whether or not they were satisfied with the outcome of each case the Center handled. This is no longer done because it is very labor intensive on the part of the Center staff, and collaborators regarded it as a burden.

Can the data system help diagnose implementation problems?

A review of case plans and field notes might provide some indications of the ways in which the Center has changed its case planning. In some instances the changes may be strategic, but other changes may be an indication of an implementation problem.

Outcome data from APS (confirmed, unfounded, inconclusive) might be utilized to determine if any action on the part of the Center helped APS to resolve a case. As the collection of outcome data from the other participating agencies is somewhat opportunistic, it is not likely that it could be used to help diagnose implementation problems.

Are there data to estimate unit costs of services or activities?

Some cost data are available, but not comprehensive. The only service payments that are tracked by the Center are payments to the UCI clinicians for chairing meetings (\$380 per each weekly meeting) or making home visits (\$475 per clinician). However, this does not cover the Center's "true costs." Each house call takes approximately 6 hours of a clinician's time (preparation, actual visit, report writing, etc), and there are usually multiple contacts via telephone and email that occur. The Center's staff spends significant time coordinating the Center's weekly meeting, maintaining the files and the database, and assisting with coordinating home visits, and these costs are not captured.

Finally, costs or cost-savings born or gained by collaborators are not captured by the Center or by individual agencies, although many collaborators claimed that the concept saves them resources and money because of resulting increases in system efficiency.

APS captures some cost data, including information relating to the recovery of assets as a result of public guardian intervention.

Are there possible comparison samples for which data is available?

Yes. As previously mentioned, both APS and the Center maintain records on the cases each entity respectively handles, and not every case receives services from the Center. Those cases that were not referred to the Center could provide a viable comparison sample to those that received its services.

What routine reports are generated?

The Center formally provides information on its activities via the Archstone Quarterly Progress Report for the Center of Excellence in Elder Abuse and Neglect. These reports contain the following: Client number, Referral Date, Age, Elder or Dependent Adult, Sex, Ethnicity, Referred By, Referral Agency, VAST Case (Y/N), VAST Number, Meeting Date, VAST visit date, Suspected Abuser (relationship), Other Forensic Center Collaborators Involved, Case Closed with Center (Y/ N).

Overall, how useful are the data systems to an impact evaluation?

Current APS and Center data systems could be useful in establishing a comparison group for an outcome evaluation. Propensity scores could be used to identify APS clients that did not receive Center services who are most similar to those clients that did receive Center services. The propensity scores would be derived from client characteristics that are documented by APS. An outcome evaluation could use existing databases and caseloads to measure prosecution and APS outcomes, and recovered assets in financial abuse/exploitation cases.

Baseline data on measures that could be used to document systems change was not collected prior to the establishment of the Center. Therefore, there are no data systems that can be used as outcomes for an impact evaluation. Changes in arrest, prosecution, and substantiation rates may be available and may be indicative of positive change. However, as mentioned previously, more aggressive prosecution strategies (e.g., accepting more difficult cases) could lower the number of successful prosecutions. Similarly, arrest is often not the desired outcome in many elder mistreatment cases.

Can target population be followed after intervention?

Center officials stated that their ability to follow subjects after their role has concluded in the case (whether through final disposition of the case or lack of pursuit of the case) is severely limited. Neither the Center nor APS is allowed to follow-up on cases, as they must wait for another report to come in once a case is closed (and there is incentive to close cases). This has been a source of frustration for Center leadership. An evaluation that relies on following victims after cases are closed would require the victims' agreement to participate in a research project, and would require specific permission for

the researcher to contact them in the future. The only other option would be to use subsequent victimization (another referral) as the outcome measure.

What is the evidence that the program is effective?

All Center participants claimed that the model has improved Orange County's response to elder abuse cases by increasing the system's ability to achieve "the right outcome" for victims, caretakers and perpetrators. They cited anecdotal information about increases in prosecution rates as well as increased reports to APS as evidence that the Center is having an effect. However, there is little empirical data to support the program's effectiveness, with the exception of the group satisfaction and perception study previously referenced in this report.

Is random assignment possible?

Random assignment is not practical for both ethical and operational reasons. Ethically, Center participants do not feel that it is appropriate to turn cases away based on arbitrary, randomized research guidelines should actors require input or assistance with particularly challenging case elements. Cases that are referred to the Center are likely to be more complicated or involve incidents of more severe abuse, and to interfere with the Center's ability to assist with any case that would benefit from its help is ethically questionable. In addition, interfering with the case referral process would operationally alter the delicate relationships that the Center has worked very diligently to establish among partner agencies. This may have an adverse effect on the Center's operations.

If not, how valid a comparison group can be formed?

A valid comparison group could be created by sampling cases that APS workers did not refer to the Center. Approximately half of the APS workers on staff do not refer any cases to the Center regardless of whether the case would benefit from the Center's input. Reasons for this lack of referral include a basic reluctance to present cases in a group setting and stylistic case management differences from those who do refer cases regularly. Cases are not assigned according to type of suspected abuse or other substantive case difference. Rather, case assignments tend to be made based on geographical considerations, which could be controlled for in the data analysis.

A pre-post Center establishment (intervention) is not a valid design to consider. As previously mentioned, pre-Center data on elder abuse prosecutions was not maintained, and therefore a pre-post comparison of elder abuse case outcomes Orange County is not possible.

What services would they receive? Could they be considered "business as usual"?

The comparison group would receive services on a "business as usual" basis, rather than the full coordinated response of the Center. This comparison group may differ from the intervention group due to case severity/complexity, geography, and differences in how particular APS workers approach their cases in terms of investigative methods and depth of involvement. Accounting for these differences would require a sophisticated research design and analysis plan.

What effect sizes are likely to be detectable?

With a steady caseload confirmed through interviews, and a total number of cases thus far equaling 448 Center cases and an equal or greater number of available APS/comparison cases, it is very possible that a well-designed outcome evaluation could detect mild to moderate effects. No preliminary analyses have yet been performed in support of this.

What is the intervention to be evaluated?

The intervention is the use of a co-located, multidisciplinary team with a medical/forensic component to address elder abuse cases that involve physical, sexual, or financial abuse, as well as neglect.

What outcomes could be assessed? With what measures?

The outcomes that could be assessed, as well as the measures used to accomplish such an outcome evaluation, are difficult to identify. Dr. Mosqueda compared the level of difficulty associated with the identification of outcomes and measures in this area to “picking up Jello,” as they are not necessarily traditional or obvious. For instance, while one might assume that prosecution rates could be a measure of the intervention’s success, this is not necessarily appropriate should such an outcome adversely affect the victim. In addition, Dr. Mosqueda identified the addition of an elder abuse focus to the Anaheim Family Justice Center’s mission as a positive result of the Center, but was unsure of how to measure this result in terms of a positive outcome of the Center’s work. When the team examined the possibility of exploring outcome measures previously, a literature review revealed little guidance for multi-disciplinary response teams and elder abuse intervention evaluations. One particularly problematic challenge is that the victims cannot be followed after they leave the system. In addition, and as previously stated, law enforcement and prosecution data is difficult to access and interpret, as many cases of abuse against the elderly are not prosecuted as “elder abuse,” but as “fraud” or “domestic violence.”

Some initial process outcomes that could be measured include APS case findings, which collaborators contributed what elements to the investigative process, and the substantive contributions of the VAST team to investigations. Outcome variables that could be measured include the comparative reduction of risk of abuse and health complications to elderly individuals who do and do not receive the Center’s intervention, quantification of increased efficiencies regarding case investigation, the impact on case prosecution and outcomes, and comparative measures of recovered assets from financial abuse/exploitation cases.

What would an evaluation of this project add to knowledge?

If a rigorous evaluation could be performed, the results of such a project would be very valuable to communities that are interested in developing a coordinated response to elder abuse case investigation and victim response. Currently, the states of Washington, South Dakota, Arizona and Texas expressed interest in replicating the Center’s work in their own jurisdictions. The most innovative aspect of the Center model is the inclusion of the medical/forensic component in the process. Process information on how such a

component is incorporated into elder abuse response, and outcome information regarding the value of their involvement may lead to inclusion of such expertise in elder abuse investigations on a more widespread basis. This development could assist law enforcement by increasing their investigative capabilities in light of the complicated medical, cognitive, and pharmaceutical issues that are presented by elderly victims. Prosecutors would more readily gain access to expert medical testimony to build cases, and have a more direct line of communication with those who are collecting evidence to build cases. Data on risk reduction to victims would inform APS workers as to the value of coordinating their response with those of law enforcement, the medical community, public guardianship entities, and victim advocacy.

Is the grantee interested in being evaluated?

Dr. Mosqueda and all interviewed partners endorsed the idea of an impact evaluation of the Center. Although Dr. Mosqueda stated that an independent evaluation is a “scary prospect,” she and the other interviewed parties expressed confidence that it would only assist them in “selling” the Center concept.

Are they willing to make changes to accommodate evaluation?

The Center is not willing to change the way it reviews cases to accommodate an evaluation, and it is unlikely that they would agree to a design that involves random assignment of cases to be reviewed by the Center.

Are they planning an evaluation?

The Center has sought funding for evaluation in the past, but does not have active plans currently to do so.

What are the largest threats to a sound evaluation?

Dr. Mosqueda expressed some concern that independent evaluators would not be able to access all of the records necessary to an evaluation due to confidentiality concerns. In addition, the aforementioned threats to sustainability (funding, space) could interfere with the completion of a long-term evaluation.

What hidden strengths/weaknesses exist?

Orange County, CA has three particular strengths that contribute to the Center’s success. First, California has multidisciplinary team legal provisions in place that allow team members to share case information across agencies without violating HIPPA or other privacy statutes. In addition, when we asked one participant if there were any elements present in Orange County that other jurisdictions would need to successfully form an elder abuse forensic center, he replied that those jurisdictions would be smart to “clone Laura Mosqueda.” Throughout the interview process, Dr. Mosqueda was identified as the charismatic driving force behind the Center’s success. While this is an asset to Orange County, it hinders the prospects of successful replication. While nearly everyone agreed that a dynamic leader was necessary to the success of the Center, most agreed that the leader did not need to be a physician. Finally, Orange County is a very wealthy jurisdiction, which contributes to staffing levels and availability of other resources to which other jurisdictions may not have access.

Would you recommend an evaluation? If so, what type?

The prospect of a process and outcome evaluation of the Center is not without design and operational challenges. First, since data was not collected prior to the Center's creation, the evaluation cannot rely on a pre-post design and reflects possible challenges to obtaining baseline data to inform the project. Second, the independent evaluation team would require access to confidential information captured by APS and Center records, the quality and completeness of which have yet to be determined. Such access is not guaranteed at this time due to HIPPA and other confidentiality provisions and practices, and this would have to be immediately and convincingly addressed by the evaluation plan. Third, the Center is currently operating without a dedicated funding stream and is in jeopardy of losing its current co-location space in Orange County's APS agency. Finally, the Center's leadership expressed support of the concept of evaluating the Center, but recognized that there is some risk involved for them. They also openly stated that they inherently assume that the Center makes a positive difference in case management and service provision outcomes to vulnerable adult abuse victims and Center participants.

In spite of these initial challenges that we have identified, we strongly recommend that NIJ pursue an evaluation of this model of collaborative response to elder abuse. The field of elder mistreatment would greatly benefit from both a process and an outcome evaluation of this program, since the model is now being replicated across the country with little empirical data to support such replication or to identify the aspects of the model that are essential to its success. The model is also very innovative, and has garnered much anecdotal praise and strong support from influential leaders in the elder mistreatment field who will likely continue to encourage its replication with or without empirical evidence of its effectiveness. We are confident that the challenges we identified through this innovation assessment can be countered by strong evaluation design methods, advanced planning for identified operational challenges, and collaborative efforts on the part of the Center leadership and an experienced, independent evaluation team.

This report has identified viable evaluation designs that take into account the difficulties of gathering baseline data retrospectively and the impossibility of random assignment. In addition, data produced by the use of a comparison sample using propensity scores will provide valid outcome data should case records be complete and available. To ensure this, a pipeline analysis of these sources will need to be performed prior to launching the project. In terms of the information to be gained by these evaluation designs, the proposed process evaluation will quantify cost and gained efficiencies associated with the Center's operations, as well as provide concrete guidance to those jurisdictions that hope to duplicate the model. The proposed outcome evaluation design would use existing databases and caseloads to measure the impact on case prosecution and outcomes, and comparative measures of recovered assets from financial abuse/exploitation cases. Measurement of the effect of the Center on a victim's future safety/risk of abuse would be performed through the collection of new data, which is possible through the design that is recommended in this report.

The most significant challenges to the successful evaluation of this program are operational in nature, rather than methodological. These challenges are surmountable based on the information gathered during the Innovations Assessment process. The availability of confidential Center or APS records to the chosen evaluation team will have to be a pre-requisite for NIJ's support of the project, and the Center leadership expressed significant interest in both the prospect of an evaluation and in assisting NIJ in working through this challenge. In addition, data access and confidentiality issues would be clearly emphasized and enumerated in the solicitation as an issue that applicants must adequately plan for and clearly address in their proposal.

Should an evaluation of the Center have the support of NIJ leadership, the Center's current and future sustainability can be quickly assessed by NIJ staff managing this project. At the time of this innovation assessment, the availability of funding and space for the Center was an evolving issue, and would be thoroughly updated prior to the production of an evaluation solicitation. In addition, the Centers' members all emphasized that it been operating for over a year without a dedicated, formal funding stream, and this has not impacted its functions or perceived effectiveness. Center leadership has stated that it has learned to "creatively adapt" in terms of producing funding when necessary to support the medical personnel's role, and the other costs associated with the Center are minimal. While a dedicated funding stream is preferable in terms of assuring sustainability, there were no indications that a lack of dedicated funding was impacting the present operations of the Center, and may therefore pose little threat to an evaluation. In addition, the loss of co-location space was a hypothetical challenge at the time of the innovation assessment, and its likelihood of occurring can be re-assessed should NIJ leadership support an evaluation of the Center.

The Center's leadership, although they have honestly expressed concern about the inherent risks associated with their support of an independent evaluation of their program, strongly supports the Center concept and is enthusiastic to assist in its assessment. In NIJ's experience with program evaluation, it is not unusual for a program's leadership and staff to inherently assume that their work is making a positive impact, as is the case with the Center's participants. In addition, the Center has applied to NIJ in the past for funding to support their own evaluation efforts, so the concept of evaluation is one that they highly value and prioritize. Their expressed anxiety about an independent evaluation did not suggest an unwillingness to participate or support NIJ's efforts in this regard. Rather, they were forthcoming with the challenges to such an effort, and were willing to work with NIJ to resolve any that arose. The possible impact and current rate of dissemination of this model of elder abuse case investigation warrant NIJ action and investment in evaluating its effectiveness.

Site Visit Meetings and Contact Information

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Site Visit Schedule and Participants

12/11/06

Cherie Hill (Anaheim PD)
Carol Tryon (Human Options-Domestic Violence Shelter)
Ken Johns (Public Guardian)
Mark Odom (Older Adult Mental Services)

12/12/06

Drs. Laura Mosqueda, Solomon Liao, & Lisa Gibbs (UCI School of Medicine)
Dr. Aileen Wigglesworth (UCI Elder Abuse Forensic Center)
Dr. Schneider (LA Forensic Center)
Craig Cazares (Deputy District Attorney)
Ronda Roberts (Victim Advocate, Office of the Orange County District Attorney)
Ken Smith (OC Sheriff Dept.)
Carol Mitchell (Program Mgr. Adult Protective Services)
Mary O'Callaghan (UCI Center for Excellence in Elder Abuse)