



National Institute of Justice

Elder Justice Roundtable: Medical Forensic Issues Concerning Abuse and Neglect

October 18, 2000

The opinions and conclusions expressed in this document are solely those of the authors and do not necessarily reflect the views of the U.S. Department of Justice.

NCJ 242221

Elder Justice Roundtable: Medical Forensic Issues Concerning Abuse and Neglect

Attorney General Janet Reno's determination to generate comprehensive solutions in the area of elder abuse and creation of the U.S. Department of Justice Nursing Home Initiative culminated in a medical forensic roundtable held October 18, 2000. Twenty-seven experts gathered to discuss the interrelated medical, legal, and organizational issues concerning elder justice. The discussion focused on four topics: detecting and diagnosing elder abuse and neglect, applying the forensic science, educating the healthcare profession, and developing a research agenda.

A consensus emerged that an inadequate research base, lack of education, insufficient coordination, and poor planning nationwide have made it difficult to prevent, detect, diagnose, intervene, treat, and prosecute elder abuse and neglect.

Attorney General Reno told participants that the roundtable was a groundbreaking step toward successfully addressing elder abuse and urged a multidisciplinary approach.

[Executive Summary](#)

[Introduction](#)

[Opening Remarks](#)

[Detection and Diagnosis](#)

[Application of the Forensic Science](#)

[Education](#)

[Research](#)

[Preparatory Time for Remarks to the Attorney General](#)

[Report to the Attorney General](#)

[Wrap-up and Next Steps](#)

[Agenda](#)

[Participants](#)

[Participant Profiles](#)

[Observers](#)

[Short Papers](#)

[Transcript](#)

Executive Summary

On October 18, 2000, Attorney General Janet Reno convened a group of preeminent experts for a groundbreaking roundtable discussion of medical forensic aspects of elder abuse and neglect. The roundtable discussion—entitled *Elder Justice: Medical Forensic Issues Relating to Elder Abuse and Neglect*—was, according to the Attorney General, a "profound step toward successfully addressing elder abuse."

The panel of 27 experts represented a variety of professions and areas of expertise, including geriatrics, forensic pathology, family medicine, psychiatry, pediatrics, gerontology, nursing, social work, psychology, emergency medicine, adult protective services (APS), and Federal, State, and local law enforcement. Prior to the discussion, participants submitted brief papers. The papers are included in this report as appendix E; a transcript of the discussion is included as appendix F.

The discussion focused on four distinct but overlapping subjects relating to elder abuse and neglect: (1) detection and diagnosis, (2) application of forensic science, (3) education and training, and (4) research. At the conclusion of the discussion, participants briefed the Attorney General on the status of each area, described what they would "take home" from the discussion, and offered

recommendations for the future. Participants agreed that it was imperative for detection and diagnosis to identify indicators of abuse and neglect and to develop an instrument to screen for elder abuse and neglect.

A general consensus emerged among the participants: Elder abuse and neglect is a national issue that has been overlooked, underreported, and understudied. As a result, we miss too many cases of elder abuse and neglect, victims too often do not receive adequate treatment and remain at risk, and even when indicated, referrals to forensic experts and reports to APS or law enforcement are rare.

Indeed, the experts were of the view that the state of medical and forensic science relating to elder abuse and neglect in the year 2000 is about the equivalent of where child abuse was 30 years ago. Given the lack of the most basic scientific research on all aspects of elder abuse and neglect, the experts pleaded for a national multidisciplinary research agenda to ascertain the real scope of the problem and whether interventions and treatments are working. The experts also described the frequent inability of frontline responders and others to detect or diagnose elder abuse and neglect; the paucity of adequate education and training on these issues; inadequate efforts among the healthcare, social service, and law enforcement professionals to collaborate in responding to elder abuse and neglect; and no comprehensive effort to address the issue nationwide. These factors have made it extremely difficult for professionals to effectively prevent, detect, diagnose, treat, intervene in, or, where necessary, prosecute elder abuse and neglect.

Detection and Diagnosis

The expert panel concluded that elder abuse and neglect is an underdiagnosed and underreported phenomenon based on several factors, including the following:

1. **No established signs of elder abuse and neglect.** There is a paucity of research identifying what types of bruising, fractures, pressure sores, malnutrition, and dehydration are evidence of potential abuse or neglect. This impedes detection and complicates training. Some forensic indicators, however, are known. For example, certain types of fractures or pressure sores almost always require further investigation, whereas others may not require investigation if adequate care was provided and documented.
2. **No validated screening tool.** There is no standardized validated screening or diagnostic tool for elder abuse and neglect. Such a tool could greatly assist in the detection and diagnosis of elder abuse and neglect and would serve to educate, and, where appropriate, to trigger suspicion, additional inquiry, and/or reporting to APS or law enforcement. Research is needed to create and validate such a tool.
3. **Difficulty in distinguishing between abuse and neglect versus other conditions.** Older people often suffer from multiple chronic illnesses. Distinguishing conditions caused by abuse or neglect from conditions caused by other factors can be complex. Often the signs of abuse and neglect resemble—OR ARE MASKED BY—those of chronic illness. Elder abuse and neglect is very heterogeneous; medical indicators should be viewed in the context of home, family, care providers, decisionmaking capacity, and institutional environments.
4. **Ageism and reluctance to report.** Ageism results in the devaluation of the worth and capacity of older people. This insidious factor may result in a less vigorous inquiry into the death or suspicious illness of an older person as compared with someone younger. Such ageism may impede and result in inadequate detection and diagnosis, particularly where combined with physicians' disinclination to report or become involved in the legal process,
5. **Few experts in forensic geriatrics.** In the case of child abuse, doctors who suspect abuse or neglect have the alternative of calling a pediatric forensic expert who will see the child, do the forensic evaluation, do the documentation, and, if necessary, do the reporting and go to court. This eliminates the responsibility of primary care physicians to follow up and relieves

them of the burden of becoming involved in the legal process. It increases reporting because the frontline providers feel like they have medical expertise backing them up. Training geriatric forensic specialists to serve an analogous role should similarly promote detection, diagnosis, and reporting, and increase the expertise in the field.

6. **Patterns of problems.** In the institutional setting, data indicating a pattern of problems also may facilitate detection. For example, the minimum data set (MDS) information for a single facility or for a nursing home chain may indicate an unacceptably high rate of malnourishment, that-absent an explicit terminal prognosis—should trigger additional inquiry. Similarly, a survey may cite a facility for putting its residents in "immediate jeopardy" as a result of providing poor care. Or emergency room staff may identify a pattern of problems from a particular facility. In these examples, the data itself may be a useful tool in facilitating detection of abuse and neglect. This type of information is accessible not only to healthcare providers but also to others.

Application of Forensic Science

This topic was discussed in two parts: Participants first discussed "what lawyers need to prove a case of elder abuse or neglect," and then they discussed multidisciplinary teams (MDTs).

Elder abuse and neglect has been prosecuted civilly and criminally. Medical testimony is critical to ensuring the successful outcome of these cases. For example, physician testimony is critical to determine whether a particular condition is evidence of abuse or neglect, or the result of some other condition. Unfortunately, the paucity of geriatric forensic experts and rigorous research data on elder abuse and neglect makes prosecutions more difficult than they otherwise would be. The forensic pathologists pointed out that their involvement could be useful in cases involving living as well as deceased victims. A wide variety of actions can take on legal relevance in an elder abuse or neglect prosecution. For example, if a hospital emergency room consistently returns residents to a nursing home known to have problems, that fact subsequently might be used defensively by the nursing home to argue "if the facility was so bad, why were the residents returned there?"

There was general consensus that the use of MDTs can be extremely effective in investigating and addressing elder abuse and neglect. Despite diverse views about who should be included on any particular team, the panelists agreed that a team should include at least medical practitioners, social workers, and law enforcement personnel. Other potential team members include forensic pathologists, financial analysts, and members of the clergy. Different types of MDTs have been formed in communities across the country with varying functions. In a few locations, MDTs not only respond to individual cases of suspected elder abuse and neglect but also attempt to determine and address systemic problems giving rise to those individual cases.

There was general consensus that MDTs with any sort of investigative focus also should include forensic specialists and pathologists who have extensive experience in investigating suspected wrongdoing and determining whether a particular condition was caused by abuse or neglect versus other causes.

Participants also discussed another type of multidisciplinary endeavor—medical forensic centers (similar to those for child and sexual abuse). Such centers could analyze whether elder abuse or neglect had occurred and provide supporting documentation, expert opinions, and testimony, if necessary. Three different models for forensic centers were discussed: national, regional, and local/mobile. A national forensic center potentially could be broadly accessible to medical professionals via telemedicine consultations and e-mail record review. This would provide centralized national accessibility to much-needed expertise without duplicating the local infrastructure costs of creating a separate facility in various locales. Participants also discussed creating regional forensic centers, similar to forensic centers for child abuse and neglect, serving a more localized region.

Finally, there was a recommendation for mobile medical forensic units that could visit homebound and isolated older people whose plight otherwise might go unnoticed.

The group also discussed the benefits of creating a national database or network of medical forensic experts (from various disciplines) and resources, and of building relationships with university medical centers and similar institutions to promote attention to elder abuse and neglect.

Education and Training

Participants decried the lack of training in elder abuse and neglect, even for those who encounter victims most frequently, such as geriatricians, police officers, social workers, and even APS workers. Some believed that there was a low level of interest in training except to learn about State mandatory reporting laws. The scarcity of research was cited as an impediment to the design of training programs. It was generally acknowledged that determining whether abuse or neglect has occurred can be a complex inquiry given the highly heterogeneous nature of elder mistreatment. Thus, experts agreed that it was important to provide interdisciplinary training to those who come in contact with older people on the systemic and contextual factors that contribute to abuse and neglect.

The types of training recommended by participants fall into two broad categories: discipline specific and multidisciplinary. Training also should be appropriate for the level of expertise of those being trained, and training/education programs should be evaluated as to their effectiveness.

Law enforcement has moved more quickly than other professions in developing training efforts, ranging from basic training in police academies to legal training for attorneys. Although training for prosecutors is not mandated yet in any State, prosecutors in some States are voluntarily learning how to investigate and prosecute elder abuse and neglect.

Research

The participants cited a desperate need for research and for the development of a national research agenda in the area of elder abuse and neglect. Even the most basic question—"How frequently does elder abuse occur?"—cannot be answered. The experts agreed that incidence and prevalence studies relating to elder abuse and neglect are imperative. They also agreed that because of the scarcity of data on this topic, it would be helpful to pursue a few specific contained, less complex research projects (for example, to establish what types of long bone fractures are evidence of possible abuse, or what types of pressure sores are evidence of possible neglect). Broad-based research also needs to be done on what types of bruising, malnutrition, dehydration, falls, fractures, and pressure sores are indicators of potential abuse and neglect.

Research is needed in assessing all types of remedial efforts as well. And although those on the frontlines strive to protect older people, there is little or no rigorous research to verify which efforts to prevent, intervene, treat, or prosecute are effective, and to what degree.

Therefore, participants strongly recommended including a validated evaluation component in all ongoing and future programs to increase scientific rigor, legitimize outcomes, and stimulate further research spending. These efforts will enhance the body of knowledge in this area.

Participants generally were of the view that with increased grant dollars, research on elder abuse and neglect would become more "prestigious" and, in turn, attract more researchers and practitioners to the field. The experts opined that the current demographic trend toward an older population could result in heightened awareness of the issue by medical and legal professionals. In

addition, the current National Academy of Sciences study, sponsored by the National Institute on Aging, should expand the knowledge base and stimulate development of additional research proposals and funding in this area.

In sum, the experts called for increased training, coordination, funding, and rigorous research on all aspects of elder abuse and neglect. They also urged identification of a list of indicators to help all practitioners determine when fractures, bruising, pressure sores, malnutrition, or dehydration are evidence of abuse or neglect in elders. Moreover, several participants encouraged exciting and productive "next steps" and spoke of implementing what they learned during the roundtable in their respective institutions or practices.

[Back to Top](#)

Introduction

On October 18, 2000, the U.S. Department of Justice convened this roundtable discussion to focus on the medical forensic aspects of elder abuse and neglect. Participants were asked to submit a brief paper addressing one or more of the four discussion topics in advance of the roundtable. Those papers are included as appendixes to this report, along with a copy of the agenda, a transcript of the discussion (with a word index), and lists of participants and observers.

Because of the breadth and complexity of the subjects to be covered during a short time, the scope of the discussion was limited. For example, although they are important topics in their own right, financial abuse and exploitation, self-neglect, and end-of-life decisions were not within the scope of the roundtable discussion.

Participants were asked to consider how they would apply the ideas discussed at the Forum to their individual institutions or practices.

To encourage a productive conversation that would allow contributions from all, participants were asked not to present lectures. To begin dialogue on each topic, one person was asked to make introductory comments, followed by a first responder. About one hour was devoted to each of four subject areas.

The Attorney General joined the discussion for about one hour. During this time, she was presented with representative views and recommendations and engaged in discussion with the participants, followed by a wrapup.

Numerous participants urged that momentum of the Roundtable discussion be continued in some form. Participants also encouraged the U.S. Department of Justice to continue its elder justice efforts.

[Back to Top](#)

Opening Remarks

Introduction of Daniel Marcus:

D. Jean Veta, J.D., Deputy Associate Attorney General, U.S. Department of Justice

Speaker:

Daniel Marcus, J.D., Associate Attorney General, U.S. Department of Justice

Moderators:

David R. Hoffman, J.D., Assistant United States Attorney, Eastern District of Pennsylvania

Laura Mosqueda, M.D., Director of Geriatrics, Associate Clinical Professor of Family Medicine
University of California-Irvine Medical Center

D. Jean Veta, Deputy Associate Attorney General, convened the roundtable. She stated that this elder justice forum was the first of its kind. She then introduced Daniel Marcus, Associate Attorney General at the U.S. Department of Justice.

Mr. Marcus welcomed participants and explained that the roundtable reflected the determination of Attorney General Janet Reno to transform the department into a "ministry of justice" in which "the traditional activities at the Department of Justice need to be melded with social service programs and health programs and science and technology efforts to really provide a comprehensive justice program."

Marcus noted that the gathering included experts from a wide array of fields, including geriatrics, forensic pathology, psychiatry, pediatrics, nursing, social work, psychology, sociology, gerontology, family medicine, internal medicine, social science, and Federal, State and local law enforcement. Many of the participants, he noted, "have done groundbreaking research in this area, developing creative multidisciplinary response teams and clinical practices, and pursuing vital prosecutions and training efforts."

While the number of older Americans is expected to more than double in the next 30 years, Marcus noted, "we have a long way to go" in detecting and diagnosing elder abuse and neglect, developing a sufficient research base to help doctors and other professionals intervene and treat it appropriately, educating professionals in many fields, and developing multidisciplinary teams that can respond to elder abuse effectively.

Two moderators guided the day's discussions: David Hoffman, an Assistant U.S. Attorney for the Eastern District of Pennsylvania, and Dr. Laura Mosqueda, Director of Geriatrics and Associate Clinical Professor of Family Medicine at the University of California-Irvine Medical Center.

The roundtable discussion focused on four topics:

1. **Detection and Diagnosis:** What Are the Forensic Markers for Identifying Physical and Psychological Signs of Abuse and Neglect?
2. **Application of the Forensic Science:** Integrating Medical Forensic Evidence With Law Enforcement
3. **Education:** What Training Is Needed for healthcare and Law Enforcement Professionals on Forensic Elder Abuse and Neglect Issues?
4. **Research:** Setting the Research Agenda to Improve the Forensic Science of Elder Abuse and Neglect

Detection and Diagnosis

[What Are the Forensic Markers for Identifying Physical and Psychological Signs of Elder Abuse and Neglect?](#)

Presenter:

Mark Lachs, M.D., M.P.H., Co-Chief, Geriatrics and Gerontology
Weill Medical College, Cornell University

First Responder:

Ian Hood, M.D., J.D., Deputy Medical Examiner, Philadelphia Medical Examiner's Office

Elder abuse and neglect are significantly underdiagnosed and underreported.

Abuse and neglect can contribute to many common maladies, including depression, malnutrition, and decubitus ulcers (bedsores), but physicians often do not ask their patients the questions necessary to detect abuse. The similarity between symptoms of chronic disease and signs of abuse, a physician's own reluctance to investigate abuse, ageism, and reduced reimbursement issues all contribute to the failure to recognize abuse and neglect. Dementia in older people also reduces physicians' confidence in their patients' reports of abuse and neglect. Even when there are clear indications of abuse or neglect, physicians are reluctant to report them—because of the lack of research, physicians' unwillingness to investigate possible abuse and neglect, and the risk of having to testify in court when evidence is confusing or unclear.

"The state of medical science and forensic science in elder abuse and neglect in the year 2000 is about where child abuse was in 1970, when we began to look at whether or not there were diagnostic injuries in child abuse and neglect," said Dr. Mark Lachs, co-chief of geriatrics and gerontology at Cornell University's Weill Medical College. To stop abuse and neglect, communities need to establish multidisciplinary teams to examine abuse and neglect allegations, and these teams must make themselves easily available to concerned health workers who lack the expertise or time to investigate abuse themselves.

Many common ailments and disturbances among the elderly may be the result of abuse and/or neglect. Malnutrition can occur when an older person has cancer—or it could be a sign of neglect. "I think we should have an increased index of suspicion in individuals who have dementia, who have depression, who have psychosis, who can't otherwise take care of themselves [who are malnourished]," said Dr. Carmel Bitondo Dyer of Baylor College of Medicine.

Other types of data also may help in the detection of elder abuse and neglect. "If you look at the minimum data set (MDS) data (resident-level information submitted by Medicare and Medicaid recipients) from nursing homes, you will find the rates of malnourishment for people without an explicit terminal prognosis range from 8 percent of the residents to 27 percent of the residents. And there are facilities where nearly one-third of the residents have severe undernutrition. So, the suspicion ought to be just not individual cases, but also patterns of care," said Dr. Catherine Hawes, professor at the Texas A&M University School of Rural Public Health. Similarly, emergency room staff might be aware of patterns of problems at a particular facility; such knowledge could facilitate detection of individual cases.

There are few explicit "markers" for elder abuse, but certain symptoms should raise suspicions. Symptoms of disease can either cause a "false negative" by masking abuse or a "false positive," where symptoms appear to be the result of neglect. "There is, unfortunately, no absolute pathognomonic condition that says this person was abused, absent outright assault. But fractures of long bones [and] fractures of ribs almost always should be investigated further. A fracture of the hip or a fracture or a collapse fracture of vertebrae may not," said Dr. Ian Hood, deputy medical examiner with the Philadelphia Medical Examiner's Office.

Patterns of injuries can indicate neglect, said Dr. Carl Eisdorfer, chairman of the Department of Psychiatry and Behavioral Sciences at the University of Miami. "Clearly, falls in older people are more likely to lead to broken bones, but if you have a pattern of falls in a nursing home, then you know that there is some kind of neglect because patients should not keep falling," he added.

Sexual abuse of the elderly has a battery of symptoms as well, but again, these are not pathognomonic, said Ann Burgess, a professor of psychiatric mental health nursing at the University of Pennsylvania School of Nursing. Nursing home residents who have sexually transmitted diseases may be victims of abuse. Urinary tract infections also can indicate abuse, particularly if all the infected patients are housed in one room or taken care of by one aide. Vaginal bleeding is suspicious, as are certain patterns of bruising to the abdomen and pelvis. "It is a particular patterning," said Burgess. "It's really to the abdomen, where a massive amount of force has been used, and you'll see the pattern."

Older victims of sexual abuse also show psychological symptoms. They may be fearful—especially of men—or display new sexualized behavior. Other victims may withdraw by sleeping excessively (hypersomnolence) or by becoming depressed. "It is almost traumatic shock. They just go into a very different mode after the abuse," said Burgess.

Pressure ulcers are another area of concern. "Pressure ulcers in areas that are easily protected, like knees, heels, or near urinary catheters, indicate poor nursing care and possible abuse," said Dr. Hood. "Severe decubitus in a nursing home should raise everybody's index of suspicion, since it can actually be lethal," said Dr. Eisdorfer. Pressure ulcers in areas that may be hard to move or access, however, such as the hips or lower spine, may not be a sign of neglect even if they get progressively worse if they have been documented and appropriately cared for.

At present, healthcare workers avoid and ignore signs of elder abuse. Physicians simply do not like to believe that family members would abuse their aged relatives. "The belief . . . on the part of physicians—and it was true of all of us, including pediatricians, 35 or 40 years ago—was that families do not abuse their own. Child abuse, for example, we keep trying to forget, is relatively recent as something that is under suspicion on the part of emergency room [and] family practitioners," said Dr. Eisdorfer.

Ageism also prevents physicians from detecting neglect. "If an older person dies, someone says, 'Older people die. They must've died from old age, from whatever it is,'" said Dr. Wendy Wright of Children's Hospital in San Diego, California.

One study showed that normal 75-year-olds who were not victims of elder abuse or neglect had a 13-year survival rate of 40 percent, while victims of elder abuse and neglect had a survival rate of 9 percent. Dr. Lachs said: "When I present this sort of data to internists, they say things to me like, 'Mark, didn't these individuals have metastatic cancer, horrible, chronic congestive heart failure, terrible emphysema?' " When the data are adjusted for these diseases, the risk of dying after a period of abuse is still three times higher than that of normal older people. None of the death certificates from the abused group ascribed death to injury or poisoning. "There was a slightly higher prevalence of symptoms of ill-defined conditions," said Dr. Lachs.

Physicians need to learn to ask hard questions and think about the possible environmental causes for their patients' symptoms. "Any kind of bruising in an elderly, fragile individual does not necessarily mean neglect or abuse," said Dr. Hood. "One of the toughest calls to make is, first off, is it a bruise, and if it is a bruise, was it obtained innocently? Frequently, clinicians never even think to address that issue."

Clinicians also may fail to investigate emotional symptoms of neglect. In many cases, doctors simply prescribe medication for depression instead of probing for the syndrome's cause. Depression is common in older adults, but it also is a natural response to abuse or neglect. "If you don't ask, you don't find out," said Dr. Lachs. Similarly, Alzheimer's patients frequently have delusions that people are breaking into their homes and stealing their possessions. "Well, maybe they are," said Dr. Lachs. "I think we really need to get on the stick and recognize that patients are telling us something. I think we are ignoring those cries."

Even in clear cases of abuse, medical personnel are often reluctant to report abuse. "We recently had a situation where, in one month's time, two very demented, bedbound women in the same facility showed up with vaginal bleeding and tearing. And the conclusion of the charge nurse was that it was self-induced. One wonders how that can happen," said Joanne Otto, an adult protective services (APS) administrator with the Colorado Department of Human Services.

Despite the fact that 44 States require reporting of elder abuse, fewer than 10 percent of referrals to APS come from physicians and other healthcare professionals—even though, noted Otto, "almost every elderly person goes to the physician more often than probably he or she goes to his preacher."

This underreporting may be due to physicians' discomfort with the legal system. "I think there is a process going on [where physicians say] 'I suspect these are indicators, but I'm not going to make the report, because then I get brought into the system and I may have to testify,'" said David Hoffman, an assistant U.S. attorney in Philadelphia.

This lack of data makes it difficult to determine the true incidence of elder abuse. "It's like in child abuse. It's important to look at and to evaluate the deaths because you learn something about the less significant injuries. But until you do that, you're not going to have a real handle on what the incidence is," commented Dr. Patricia McFeeley, assistant chief medical investigator at the University of New Mexico. The forensic markers of abuse are unknown. "I think that just like Sudden Infant Death Syndrome or Shaken Baby Syndrome, until we started doing autopsies on children who died, we did not realize there was a difference between the two. There could be a constellation or a pattern of injuries in elderly people that could be a forensic marker but currently is not being recognized because of the lack of information after death," said Dr. Wright.

Unfortunately, physicians consistently fail to order autopsies, even in cases where the death is suspicious. Dr. Erik Lindbloom, a geriatrician and assistant professor of family medicine at the University of Missouri, examined every 1997 Missouri death certificate where dehydration and malnutrition were listed as the primary or secondary causes of death. "I found no postmortem exam or other investigation after the fact," said Dr. Lindbloom. Deaths in nursing homes are not investigated unless there is some substantial cause for suspicion.

Some simple procedural changes can protect patients. "Where you have had one incident in a particular nursing home or chain of nursing homes, as a form of monitoring you can now say you're not allowed to sign your own death certificates. Anyone who dies in that institution must now be referred to the medical examiner's office," said Dr. Hood. "It is relatively easy to start a case file, and it is remarkably effective at maintaining awareness in that nursing home or personal care facility that it is being monitored, and that alone is all you need."

This state of affairs must change. Primary care physicians are important gatekeepers for abused elders. "For an older person, that annual visit to a physician may be the only contact that the individual has with someone outside the abusive situation," said Dr. Lachs. Even patients who do not come to their appointments may be communicating vital information. "[Look at] the lack of contact, frequent missed appointments, for example, or mildly demented elders coming to a clinic alone, maybe put on public transportation to get to their clinic appointment with no one accompanying them," noted Dr. Lindbloom.

Improved screening by emergency departments, primary care practices, and other medical specialties will help detect elder abuse and neglect, as will efforts that effectively involve law enforcement personnel. In South Carolina, researchers have put together an adult abuse protocol for healthcare workers. "It provides a structured way for physicians to screen for possible suspected cases of abuse or neglect," said Randolph Thomas, a police officer and law enforcement instructor with the South Carolina Department of Public Safety. The protocol also takes advantage of South Carolina's existing child abuse protocols. "Our law enforcement people are familiar with the forensic package that goes with this. They are familiar with the fact that it is an evidence-collection issue and has to be handled properly," said Thomas. "I think a vital component can come from law enforcement and a prosecution arm so that people know where to call, or when they have a suspicion know whom to contact," said Bill Gambrell, assistant deputy attorney general with the South Carolina Attorney General's Medicaid Fraud Control Unit. Social workers and nurses who engage in home healthcare also could help identify abuse and neglect.

At present, law enforcement and APS workers are not working together efficiently. "Law enforcement needs to be included in this process. While in Philadelphia, it may go to a detective, I can tell you I have ridden with beat officers who get calls on a regular basis to go out to homes because some neighbor dials 911 and says, 'Do something.' And that beat officer spends 4 hours at a home waiting for APS to show up because it takes that long for an APS worker to get notified that they need to do an emergency investigation," said Dr. Gregory Paveza, an associate professor at the University of South Florida's School of Social Work.

Part of the problem is that in many States, there is no good system for dealing with elder abuse. In the case of child abuse, doctors have an easy alternative. Dr. Wright, a pediatrician, commented: "What they can do is call me in a heartbeat. I will see the child, do the whole forensic evaluation, and then do the reporting, do the documentation, go to court. So, it eliminates their responsibility to follow up. It increases the reporting because they feel like they have some backup in terms of medical expertise." The lingering question is, who will pay for these forensic services—for children or for older people? "If we're going to legislate reporting of elder abuse, we have to also include in it funding and some streams of resources to the people who are going to have to do that work," said Dr. Wright.

There may be support for forensic evaluations of older people from an unexpected ally: fraud investigators. "They are starting to investigate whether the person is being physically neglected as a way of hastening their death," said Lisa Nerenberg, M.S.W., consultant, elder abuse prevention.

[Back to Top](#)

Application of the Forensic Science

Integrating Medical Forensic Evidence With Law Enforcement

Presenter:

Candace Heisler, J.D., Consultant and Trainer, San Francisco District Attorney's Office (Retired)

First Responder:

Charles W. Gambrell, Jr., J.D., Assistant Deputy Attorney General, South Carolina, Attorney General's Office Director

Elder abuse and neglect have been successfully prosecuted in both criminal and civil contexts. Individuals have been held criminally liable for their abusive and neglectful actions against older people in home and institutional settings. Corporations have been deemed liable for allowing residents of long-term care facilities to suffer egregious injury or even death as a result of neglectful care. Medical testimony, however, is critical to ensuring a successful outcome to these cases.

For example, prosecutors need help from physicians to resolve whether an injury is evidence of abuse or neglect, or simply the result of aging, disease, or accident. Prosecutors will rely heavily on medical professionals for diagnosis and identification of injuries, as well as recognition, documentation, and reporting of the conditions found. Law enforcement also needs to know whether medical professionals will provide opinion testimony as to medical causation of the injuries and harm associated with poor care or abusive behavior.

Candace Heisler, a former prosecutor with the San Francisco District Attorney's Office and consultant, said that physician identification of the nature of injuries in an abuse case is critical. She noted that prosecutors need answers to the following questions: "What are we looking at?" "Is it an injury, or is this some sort of result of either aging or a disease process?" The second part of this analysis includes an opinion regarding whether the injury was intentional or whether it was accidental. In other words, is there something about the location, appearance, or type of injury that addresses the intent issue? In terms of neglect, law enforcement will look to medical professionals to answer questions such as whether adequate care was rendered for the victim's medical condition, and whether the resultant harm was proximately caused by the action or inaction of the caregiver.

Charles W. "Bill" Gambrell, director of the South Carolina Attorney General's Medicaid Fraud Control Unit and an assistant deputy attorney general, noted that in prosecuting elder abuse cases, he found there was always a doctor on the other side who testified "there are 10,000 other logical explanations for the bruises that start from the forehead and go down to the shins." "That," he noted, "is why it is so crucial early on to have competent medical advice in these matters." But there often is a general reluctance on the part of doctors to get involved in elder abuse and neglect cases.

In nursing home cases, too often, the responsible owners or operators are not held responsible. Mr. Gambrell opined that the 100-percent conviction rate (in 60 to 70 abuse cases) that his office has amassed in South Carolina during the past 5 years indicates that prosecutors are going after only "the obvious people—nurses and attendants," he said. "I think the people further up the system in facilities—directors of nursing, administrators, the doctors who are responsible for overseeing the care of the individuals in the facilities—have a significant liability."

In South Carolina, as in many parts of the country, police have two problems, said Randolph Thomas, a police officer and law enforcement instructor with the South Carolina Department of Public Safety: finding an emergency room physician who understands trauma generally and abuse specifically; and finding a medical practitioner who will render an opinion, even a nonattributable

one. Police often learn of abuse only when a practitioner tells them of suspicious circumstances. However, he said, "The quickest way to clear out a hospital emergency room is to wave a subpoena for a physician."

It is not always necessary for doctors to testify if adequate documentation exists. For example, Dr. Carmel Bitondo Dyer, a geriatrician and associate professor of medicine at Baylor College of Medicine, noted that her department often receives calls from police officers requesting an opinion about whether abuse has occurred, and such opinions often can be rendered based on adequate documentation by attending physicians. The larger problem facing police is that patients often lack the capacity to testify effectively.

In those cases, Candace Heisler, the former assistant district attorney, noted that prosecutors can learn from their experiences in dealing with domestic violence and child abuse cases, in which successful cases are built that "don't rest on the shoulders of the victim." If all the pieces of a case are assembled from the beginning, prosecution can go forward without the victim's participation.

Because of physicians' reluctance to become involved in legal cases, it is important that medical examiners be called early to verify cases of elder abuse, said Dr. William Hauda, a pediatrician, emergency physician, medical examiner, and adult services medical director at the INOVA Fact Center in Falls Church, Virginia. Often, neither a family doctor nor an emergency room physician, both of whom have seen the victim, want to testify "because they earn more money working than they are going to earn in court." It is important, therefore, that the medical examiner actually see the victim, he said, so that the prosecution has an effective witness who can testify from direct observation rather than by relying on medical records.

As in child abuse cases, Dr. Hauda noted, forensic physicians can help investigators plan their approach in elder abuse cases, which should include documenting the case fully when an emergency department finds a suspicious factor and amassing the records and information needed for a case to proceed. The police and adult protective services (APS) should take the initiative in identifying experts who are willing to review cases and examine victims of suspected elder abuse or neglect.

To encourage physician testimony, Dr. Hauda said, it is important to find ways to pay for a physician's time supporting the legal process. In Virginia, a new law makes it possible for a Commonwealth Attorney (city or county prosecutor) to pay a physician to evaluate any victim of any crime.

Several participants expressed the view that there is not a sufficient number of experts in most jurisdictions. Thomas, for example, noted that South Carolina has only three forensic pathologists—a shortage that is not unique. Experts in elder abuse may exist, he said, but "[T]he truth is, law enforcement does not know who they are. We do in child abuse. We have learned that over time. But right now we do not [know the elder abuse experts. . . .] There is no handy-dandy list you reach for at 11 o'clock at night in somebody's home when you need to talk to somebody, nor do we have . . . many level-one trauma centers."

Dr. Erik Lindbloom, a geriatrician and assistant professor of family medicine at the University of Missouri in Columbia, agreed, noting that a pathologist at the University of Missouri, who is an expert in forensic pathology and elder abuse and neglect, took it upon himself to learn some warning signs when he realized no one else in the State seemed to have the expertise or interest.

Since there is a shortage of geriatric physicians, more primary care physicians should be trained in geriatrics, said Dr. Rosalie Wolf, executive director of the University of Massachusetts Memorial healthcare Institute on Aging.

To overcome this dearth of experts, police and prosecutors must develop multidisciplinary teams and find doctors to train members, Gambrell said. Physicians would be less reluctant to testify if a team included a nurse, a social worker, and an APS worker who can help the street police officer and turn the case over to him. The ideal, he said, is to provide guidance so that a physician is not required, even in the courtroom. "I actually have prosecuted cases without doctors as experts," he said, "just because I couldn't get a doctor . . . and have had to rely on another level of medical expertise."

Even though medical professionals may be reluctant to report signs of abuse or neglect, most States have mandatory reporting laws that require a physician to report and possibly begin an investigation, noted Dr. Wendy Wright, a pediatrician at San Diego's Children's Hospital. "It is not my job as a physician to decide the outcome of my report," she said. "That is why there is an investigative process and why there are multidisciplinary teams." While some medical professionals fail to report abuse because they don't want the victim to have to leave home, or they don't want the perpetrator to go to jail, the fact is that by failing to report, they have broken the law and denied the victim the services to which he or she might be entitled.

David Hoffman, assistant U.S. attorney in Philadelphia, added, "I guess we should disabuse people of the notion that somebody is going to jail in every case." There are, he said, civil as well as criminal remedies to stop people from neglecting and abusing older people, especially in institutions, and ways to keep people from acting in a fashion that jeopardizes older people.

A network of elder shelters is beginning to form, but there still are few shelters and little funding, said Dr. Wolf. Some elder victims do not want to be separated from their abusers—their only companions, perhaps, for 50 years or more, and would rather stay than go to a nursing home. More than 60 percent of abusers are family members, noted Joanne Otto, an APS administrator with the Colorado Department of Human Services.

Models for sanctuaries from violence can be found among those for victims of child abuse and domestic violence, said Ann Burgess, professor of psychiatric nursing at the University of Pennsylvania. Elderly victims certainly need shelters, she said, but special efforts must be made to deal with their fear of retaliation from their abusers.

Multidisciplinary Teams

Elder abuse can be investigated and diagnosed best by multidisciplinary teams that include medical practitioners, police, social workers, and a variety of specialists. The specialists can include financial analysts, members of the clergy, and even professionals from such unlikely fields as architecture, all of whom can be called in as needed.

Multidisciplinary teams can be especially effective in assembling and reporting data and in providing the basis for advocacy in seeking support and funding. In sparsely populated areas, the shortage of specialists such as geriatricians and forensic pathologists makes it advisable to concentrate on training and to establish panels of specialists at national and regional levels who can be called on to consult. In addition, the reluctance of general practitioners and emergency room specialists to testify in elder abuse cases hinders prosecution and must be resolved, possibly by arranging for paid testimony.

Multidisciplinary teams have been very effective in several jurisdictions. One team in Pennsylvania has been successful in developing elder abuse cases for intervention and prosecution, said Susan Renz, a nurse and consultant with RS Connection Inc., in West Chester, Pennsylvania. The Pennsylvania Attorney General's office appointed a board 2 years ago that includes prosecutors, detectives, APS workers, nurse practitioners, and geriatricians from throughout the State, as well as a representative from the Department of Health. The board reviews elder abuse cases and has been

most productive, she said, in "teasing out" cases to determine if they really have substance—a subject on which there often has been disagreement—and addressing the following questions: "If we're going to proceed, what else do we need to look for? What records do we need to get from the facilities? Whom do we need to interview? Whom do we charge and what do we charge them with? And who do we need as experts?"

Dr. Carmel Dyer said that her multidisciplinary geriatric assessment team diagnoses elderly victims and documents their symptoms. This is under the purview of geriatricians, just as child abuse is under the purview of pediatricians, she said. The team also determines whether deaths were natural or not. "We take care of these people all the time, and we follow them in long-term care," she said. In Houston, her team links the existing geriatric team at the hospital with the APS to form a resource for law enforcement that is spreading throughout the State. She said that the team does not remove patients from home. Of the 100 cases the team handled last year, it sent only 5 people to guardianship. The team makes house calls, monitors patients, and watches for problems that it can prevent, Dr. Dyer noted.

Elder abuse is heterogeneous, noted Dr. Mark Lachs, co-chief of geriatrics and gerontology at Cornell University's Weill Medical College: an Alzheimer's victim who becomes assaultive as part of his syndrome, a stressed-out caregiver who becomes briefly assaultive, an alcoholic beating up an aging parent; spousal abuse by elders. A geriatric assessment or multidisciplinary team, he said, tailors its intervention to the different needs of the alcoholic, the stressed-out caregiver, or the older abuser. Dr. Lachs agreed that the key to this is community partnerships, such as Dr. Dyer described, in which geriatricians, APS, and community service organizations join.

Dr. Catherine Hawes, a gerontologist and professor at Texas A&M's School of Rural Public Health, noted, in investigating abuse in institution, that it is important to have on a team someone who can read cost reports, understand accounting, and look for the structures that cause neglect and abuse in an institution. That way, she said, police and prosecutors can go after a medical director or a director of nursing (not to mention an owner of a nursing or personal-care home) who created the environment in which abuse and neglect was inevitable, given the way they structured resources or incentives.

Dr. Kerry Burnight, a gerontologist and assistant clinical professor at the University of California-Irvine's College of Medicine, described another successful multidisciplinary team, which also includes Dr. Mosqueda. Drs. Burnight and Mosqueda's team has funding from the Archstone Foundation for a 3-year project, and it has used the same model as Dr. Dyer's team. Also, Dr. Burnight said, her team tailors interventions in the way described by Dr. Lachs. The key players are a medical doctor, a psychologist (important in addressing capacity and undue influence), someone to address financial issues as outlined by Dr. Hawes, a social worker (important for interaction with the social workers in APS), and a gerontologist to keep track of data and evaluate activities.

Close partnerships with the police and sheriff, with the district attorney, and with the legal community also are important, Dr. Burnight said. Such partnerships are important in selecting cases and deciding what steps are appropriate—especially important because many calls can be handled with an e-mail or telephone conversation. It also is very useful for the entire team to meet regularly and review cases.

Several medical specialties can be useful on multidisciplinary teams, noted Dr. Patricia McFeeley, assistant chief medical investigator at the University of New Mexico. As with child abuse cases, a forensic pathologist may be able to identify indications of abuse better than a general practitioner, and other aspects of forensic medicine also can be useful. An odontologist can decide whether a wound is a bite mark and see whether the bite mark matches any particular biter. In sex crimes, DNA can be used to identify perpetrators.

Mr. Hoffman asked whether including pathologists in multidisciplinary teams would overcome a reluctance he finds in suburban and rural areas to perform autopsies on older people. Dr. Ian Hood, deputy medical examiner in the Philadelphia Medical Examiner's Office, and Dr. McFeeley have served on such teams. Dr. Hood noted that both feel they have been useful. Frequently, he commented, forensic pathologists are the best witnesses because they are accustomed to testifying. Even though a family practitioner may see a case and dutifully report it, he or she might not handle cross-examination as well as a forensic pathologist.

In response to a question from Dr. Laura Mosqueda, director of geriatrics and associate clinical professor of family medicine, U.C.I. Medical Center, participants identified the necessary core members of successful multidisciplinary teams.

At a clinic in Florida, said Dr. Carl Eisdorfer, a professor with the University of Miami's Department of Psychiatry and Behavioral Sciences, "we always include a neurologist and a psychiatrist." At a project in Seattle, an architect was included to deal with structural changes that might be necessary as a result of patients' falls. He said that a Veterans' Administration project he runs uses both experts in geriatric medicine and geriatric psychiatry. The latest data on that multidisciplinary team, he said, indicate that it may save money, since early detection of depression and cognitive disability changes the nature of medical and, often, surgical care.

Dr. Dyer specified that a core team should include a "doctor, nurse, social worker—those are already well-established, the traditional members of interdisciplinary teams—and an APS specialist. Absolutely." And Dr. Gregory Paveza, an associate professor at the University of South Florida's School of Social Work, added that it should include a law enforcement officer and an attorney, preferably a prosecutor.

To address financial exploitation, Dr. Wolf said, "you really need somebody on that team who represents financial planning and the whole financial picture." A few States require a multidisciplinary team that meets at the insistence of the APS supervisor. In Illinois, she added, a member of the clergy is included on the team.

There are many models of multidisciplinary teams, ranging from an APS unit that sends a nurse and a police officer to investigate cases, in which it appears their expertise will be needed from the start, to a 50-person fiduciary abuse specialist team in Los Angeles, noted Lisa Nerenberg, a consultant in private practice in Redwood City, California. Clearly, she said, large teams are pulled together not to discuss individual cases—although they often do—but to develop and exert expertise. The Los Angeles team, she said, was one of the first groups to raise the connection between physical abuse and financial motive. When a large number of people join a team, she said, they start to make this sort of connection and to create specialized expertise.

Her own team really turned a corner, Ms. Nerenberg said, when Ms. Heisler came to a meeting to discuss a case she was going to prosecute. She spoke with social service workers and medical people, as well as other specialists, "telling us what she had to prove, saying, 'these are the elements of a crime, these are the standards that I need to reach.' It got people thinking very differently. They became partners in a process."

Dr. Mosqueda serves on both the Los Angeles and Orange County (California) fiduciary abuse teams and agreed that these teams "get huge." But, she said, their purpose is not merely to identify financially inspired abuse. "We educate each other very much," she said, "and part of the reason the team is so huge is because everybody wants to learn more about it."

Forming a national forensic center with related regional centers might be helpful in assuring the availability of experts, said Marie-Therese Connolly, coordinator of the U.S. Department of Justice

Nursing Home Initiative in Washington, D.C. Dr. Lachs agreed that national or regional forensic centers are a good idea and noted the critical shortage of geriatricians, who are necessary for successful teams. In rural areas, especially, he said, there will have to be some sort of forensic center infrastructure. These should be at the State or regional level and include specialist teams to handle cases in small jurisdictions.

In rural areas, Dr. Lindbloom said, members of the clergy and community leaders should be included in teams to help professionals understand issues that patients and family members might face at home.

Telemedicine may offer another solution, said Dr. Arthur Sanders, a professor of emergency medicine at the University of Arizona in Tucson. A team does not have to be sitting in the same room. A geriatrician must be involved, but local physicians could make home visits and then get advice on how to proceed from such experts as Dr. Dyer or Dr. Lachs.

[Back to Top](#)

Education

[What Training Is Needed for healthcare and Law Enforcement Professionals on Forensic Elder Abuse and Neglect Issues?](#)

Presenter:

Gregory Paveza, Ph.D., M.S.W., Associate Professor, University of South Florida School of Social Work

First Responder:

Carmel Bitondo Dyer, M.D., A.G.S.F., F.A.C.P., Associate Professor of Medicine, Baylor College of Medicine, Director, Geriatrics Program, Harris County Hospital District

Doctors, social workers, emergency medical technicians, nurses, lawyers, and other professionals need a better understanding of elder abuse and neglect to provide adequate assistance to their patients/clients. "What I want folks to begin to think about is ... Who needs to know what, and when do they need to know it?" said Dr. Gregory Paveza, associate professor at the University of South Florida School of Social Work.

Dr. Mosqueda pointed out that it is important to provide training at the right level. "One overarching theme, almost no matter what field, is [the application of a] pyramid approach—something Dr. Wright and I have used in designing training programs. [W]ho do you need to educate [and] at what level? . . . If you look at people who are geriatric experts, be they geriatric nurse practitioners, geriatricians, et cetera, that is a whole different level of expertise [for training purposes] than a medical student." Dr. Sanders echoed this point, suggesting that a consensus be developed for "What does the geriatrician need to know?" "What does the primary care physician . . . and the paramedic need to know at various levels?" Another suggestion was that education and training programs be evaluated to ensure their effectiveness.

In addition to training within each individual discipline, Dr. Mosqueda noted the importance of cross-discipline training, but said: "As physicians, we must admit that we are notoriously bad about going to multidisciplinary training." Dr. Paveza agreed, pointing out that it is difficult to get groups to cross-training, but that it is crucial to understanding the concerns of others who are part of multidisciplinary teams. Dr. Paveza noted that one way to increase attendance was to mandate training as part of license renewal.

Medicine

While this education initiative will not be an easy task, educating medical school students and physicians about elder abuse and neglect is paramount to the successful eradication of elder abuse and neglect. One way to get doctors to understand the medical importance of abuse is to compare it to chronic disease, said Dr. Mark Lachs, co-chief of geriatrics and gerontology at Cornell University's Weill Medical College. "This [abuse and neglect] has as much . . . mortality associated with it as all the other chronic diseases they normally treat . . . family violence victims of any age behave in the health system like people with chronic disease," he said.

To convince medical schools to teach students about elder abuse, geriatricians need to do more research, activists need to work to change policy, and elder deaths need to become "noteworthy," said Dr. Dyer, associate professor at Baylor College of Medicine, Texas. "Do you ever read about it in the newspaper—how somebody who was actively neglecting somebody [else] is prosecuted? Doctors are not reading that in the newspaper. It is not important," said Dyer. Many physicians regard elder abuse and neglect as "just a social issue."

Increased research, grants, and papers can convince medical school curriculum committees that elder abuse is an important medical issue, but that still will be a struggle. "When we developed the California training center for areas of all violence education ... we had people advocating at the University of California regents level, which mandates training in all of our University of California medical schools in order to get family violence on the curriculum of our seven California medical schools, and have not yet been successful ... that arena is not very promising," said Dr. Wendy Wright of the Children's Hospital in San Diego, California.

At present, there is no consensus on how to train physicians on elder neglect and abuse. "One thing would be to develop a consensus: What does a geriatrician need to know? I'm actually surprised it is not in the curriculum and in the examination ... what does a primary care physician, what does a paramedic need to know at various levels?" said Dr. Arthur Sanders, professor of emergency medicine at the University of Arizona.

Geriatricians can work state by state to make sure there are questions about aging on State board examinations, just as many States now include questions about violence on their nursing exams. Other policy changes can create financial incentives for schools to change their training. States can require medical schools that receive public funds to designate an elder abuse expert at the school. On a Federal level, Medicare can create incentives for medical schools to train more geriatricians, Dyer noted.

Doctors who already are licensed also need to be trained in elder abuse and neglect.

Physicians are required, under law, to report abuse. "There were physicians that were prosecuted in the child abuse arena for failing to report, and there is some value in that from a law enforcement perspective, to inspire others to come forward," said David Hoffman, assistant United States attorney in Philadelphia. Some doctors resist investigating elder abuse or neglect because of fear of testifying; others do so because they fear lawsuits or because they do not want to report colleagues to authorities.

"A lot of what we are facing are often really instances of medical malpractice which triggers off abuse, [including] misuse of medications, withholding of visits," said Dr. Carl Eisdorfer, chairman of the Department of Psychiatry and Behavioral Sciences at the University of Miami. To increase the chances for bringing such malpractice to attention, Dr. Eisdorfer suggested adopting the "impaired physician" model, in which physicians who have problems with substance abuse can be reported and "will get help rather than prosecutorial attention." In other cases, "doctors don't like to see lawyers

because they have this vision of being cross-examined on the stand and getting involved and, if you do this, you may have to hire your own lawyer to protect you," said Dr. Eisdorfer. Attorneys and doctors need to be able to look at their colleagues' reports and judge whether abuse might be happening despite—or because of—their colleagues' efforts.

On a practical level, doctors tend to resist "interdisciplinary" or "multidisciplinary" training, preferring training developed specifically for physicians. "As physicians, we must admit that we are notoriously bad about going to multidisciplinary trainings," said Dr. Laura Mosqueda, director of geriatrics at the University of California-Irvine Medical Center, whereas nurses, social workers, and law enforcement officers are far more willing to participate.

To encourage doctors to attend multidisciplinary trainings, groups that offer them should also offer continuing medical education (CME) credits for doctors and continuing legal education (CLE) credits for lawyers, which are requirements for renewing a license to practice in many States. "It is a nice carrot, and sometimes both the physicians and the lawyers are looking for something out of the ordinary when they're going to do that, that is more than just the humdrum stuff that they may be doing every day and reading the journals on every day," said Dr. Ian Hood, deputy medical examiner, Philadelphia. In particular, quality assurance credits for continuing medical education are required, and difficult to obtain, said Dr. Rosalie Wolf, executive director at the University of Massachusetts Memorial healthcare Institute of Aging.

Changing doctors' behavior is more than just a matter of giving CME credit, noted Dr. Sanders. He added: "There is a literature on changing physician behavior, and the trap is [that] you put on a CME course and you think people visit, or you send out a position statement from a professional society, and you think people are doing it . . . there are mechanisms of [changing behavior], some through regulation, some through feedback of physician leaders, various things like that."

Social Work

Social work students are not being taught even the most basic facts about the lives of older adults. "I don't know personally of any graduate schools of social work that offer curricula in elder abuse, and that is a big gap," said Joanne Otto, administrator of APS in Colorado. The National Association for Adult Protective Services Administrators is developing standards for training, but, so far, there are no Federal guidelines for training.

Ignorance of elder issues is pervasive in colleges, down to the very textbooks assigned to students. "As an example, several years ago at a meeting I went through a gob of textbooks, literally hundreds of textbooks on human development," said Paveza. "All of them had five chapters on child development, seven chapters on adult development, and a half-chapter on old age and development of the elder adult. We need to make sure that our professionals. . . at a basic level know about geriatrics, and know about aging, and what is the normal aging process." Medical residents and professional students also need to learn about basic aging issues, so they can identify adults who are showing unusual symptoms and answer the question, "What does a pattern begin to look like that should lead you to suspect that abuse and neglect is occurring?" said Dr. Paveza.

Law Enforcement

In some States, law enforcement personnel already are learning about elder abuse as part of their basic curriculum at the police academy. State legislatures in California and elsewhere have passed laws mandating training in elder abuse for law enforcement personnel and allocating the money to provide it, said Candace Heisler, consultant and trainer for the San Francisco District Attorney's Office.

In South Carolina, police academy instructors train recruits in legal issues surrounding elder abuse and indicators of abuse. Pictures of the physical impact of neglect on the body are particularly useful, said Randolph Thomas, police officer and law enforcement instructor at the Criminal Justice Academy in South Carolina. He commented: "Most of my police officers know what a gunshot wound is. They do not know what a pressure sore looks like, and when you start showing them pictures, they start to have a frame of reference. That may be the most important thing, just that cognitive framework that says, 'Okay, this may or may not be abuse.'" Police officers want training and are capable of learning technical information about abuse and neglect. "They can tolerate a high level of sophistication, as long as it is done in laymen's terms," Thomas added.

Like many other entry-level workers, most police academy students are in their mid-20s and have difficulty sympathizing with and understanding older adults. Thomas said: "Somebody needs to teach them about the process of aging . . . They need to know how this works, that not everybody who is 85 is impaired, and a lot of my officers think they are." Many of their complainants will be elderly and could be good witnesses if the officers knew how to work with them. "I have certainly seen a 23-year-old recently promoted to detective conduct a photo ID with an 85-year-old mugging victim in a way that was obviously not going to lead to a useful result, just because of a lack of knowledge about the kind of person the detective was dealing with," said Hood. Older adults are not always eager to work with young officers, either. Thomas commented that he sometimes hears older adults say "Send me back a real adult."

Unfortunately, the police need constant retraining. "Our State is turning over about 20, 25 percent of our police officers every year . . . It is a sign of a good economy," said Thomas. He stressed that training on elder abuse needs to be institutionalized and performed over and over again. Constant retraining can be exhausting for the trainers. "In our county. . . we have 26 different police departments. And with the high turnover, it just feels like you're lecturing to a parade sometimes," said Mosqueda. This problem is not limited to policemen. "It is also important in a lot of different fields we're addressing here: APS, nursing homes," said Dr. Erik Lindbloom, assistant professor at the University of Missouri. "Residency training, by design, has a 100-percent turnover over a 3-year period in internal medicine and family practice, for example," said Lindbloom.

California's training for police officers teaches basic awareness of aging issues, plus information on effectively reporting elder abuse, including scene preservation and evidence collection. "[This] translates into prosecutable cases where a crime can be shown and a perpetrator can be identified," said Heisler. In California, advanced training on these topics is especially important because State law "authorizes law enforcement to seize assets where a public guardian is going to pursue a conservatorship . . . and where they have a basis for concluding . . . a conservatorship would be appropriate," commented Heisler—that is, where the State takes over the care of an older victim of abuse or neglect.

California officials have developed a repository of training films on aging issues for distance learning through the State's Commission on Peace Officer Standards and Training (POST), Heisler said. These films are distributed to the 500-plus police departments in the State. "Through telecourses, we bring other prosecutors in, we bring law enforcement in to explain to them how you do these cases," said Heisler. The National Center for Elder Abuse in Washington, D.C., also plans to collect training materials for different disciplines, for a sort of national repository. Other California training courses also involve aging issues; the State's domestic violence training course includes a session on domestic violence in later life.

In Florida, an interdisciplinary team including a psychologist and geriatric nursing specialist has visited 25 percent of State police departments with a multimedia presentation on elder neglect and abuse, said Dr. Eisdorfer. In the future, trainers in South Carolina and Florida need to train more trainers. "It is pretty impractical to expect someone like Randy [Thomas] to continue traveling all

over the State, all over the county, to do these presentations when we could be training people locally to do the same thing, [so they could] really take it under their wing as a cause at their medical school, at their agency, at their nursing home," said Dr. Lindbloom.

Prosecutors, however, are not nearly as well informed as law enforcement officials. "They do not have to receive training about this subject in law school, and they certainly do not have to have it for professional development in a prosecutor's office," said Heisler, although California's District Attorneys' Association offers a 3-day training course on the topic each year. The National College of District Attorneys has also added elder domestic violence and elder abuse to its roster of training courses.

[Public Health Workers, Surveyors, First Responders, and Others](#)

Public health workers also need education about elder neglect and abuse. "We have talked about how unresponsive hospitals are. Maybe we need to start educating the hospital administrators, the people in health policy and management who will run . . . local health departments, [who] can raise community awareness of this, and [who] are the people . . . running the outpatient clinics, the hospitals, the places where it might be seen, about what is needed to support the healthcare professionals [to] do both the detecting and reporting," said Dr. Catherine Hawes, professor at the Texas A&M University School of Rural Public Health.

Another group that needs training are "nurse surveyors and complaint investigators, and [employees of] State agencies who are charged . . . with investigating complaints in residential long-term care settings," said Dr. Hawes, and there is real importance in involving them on multidisciplinary teams.

Ms. Nerenberg suggested taking it one step farther to teach "health and social services providers, APS workers, some of the medical or health indicators they may need to know about." Ms. Connolly, with the U.S. Department of Justice, suggested training for firefighters, paramedics, ambulance EMTs, and other first responders, who often have no training in detection of elder abuse and neglect. She also suggested helping frontline responders develop internal screening protocols to analyze suspected elder abuse or neglect, document it, and, where appropriate make a report or referral to APS or law enforcement.

[Back to Top](#)

Research

[Setting the Research Agenda to Improve the Forensic Science of Elder Abuse and Neglect](#)

Presenter:

Sidney Stahl, Ph.D., Chief, healthcare Organizations and Social Institutions, National Institute on Aging, National Institutes of Health

First Responder:

Rosalie S. Wolf, Ph.D., Executive Director, Institute on Aging, University of Massachusetts Memorial healthcare

Dr. Sidney Stahl, chief, healthcare Organizations and Social Institutions at the National Institute on Aging (NIA), delivered "a plea for some sort of national research agenda, multiagency research agenda on elder abuse and neglect, based on the desperate need for targeted research in various kinds of areas." The lack of the most basic scientific research in the field, Dr. Stahl noted, prevents service providers and others from knowing the real scope of the problem and whether their

interventions are working. NIA and the National Academy of Sciences recently announced a 10-month study on elder abuse and neglect to help create such a national agenda for research, and Dr. Stahl outlined his own seven-point agenda.

1. **Prevalence and risk factors.** There is no nationally based probabilistic study on either abuse or neglect, and without a reasonable prevalence estimate, it is impossible to determine with any certainty the risk factors.
2. **Accurate measurements.** There needs to be a single metric that is useful and culturally sensitive across various disciplines to measure prevalence.
3. **Natural history of abuse and neglect.** Is elder abuse a learned response to stressors occurring within the family? Is frailty a precursor or result of elder abuse and neglect? The answers to these questions will dictate the kinds of interventions used.
4. **Lack of diagnostic specificity.** While depression is common for the elderly, it also may be an appropriate response to an abusive and neglectful situation. There needs to be a clearer medical causation established through research.
5. **Lack of scientifically verified prevention interventions.** At present, there are only two studies on abuse and neglect that meet the criteria for scientific adequacy of the National Academy of Sciences. Clearly, more are needed.
6. **Issue of self-neglect.** There is a need to determine the economic and social cost-effectiveness of community services versus nursing homes in self-neglect situations.
7. **Institutional abuse and neglect.** What are the characteristics of nursing home workers and the environment that lead to abuse and neglect in institutions?

Dr. Rosalie Wolf, executive director of the University of Massachusetts Memorial healthcare Institute on Aging, echoed Dr. Stahl's assessment of the paucity of research in the field, particularly as it relates to intra- and interpersonal dynamics and the contextual and societal factors that lead to abuse, as well as the consequences of such abuse. Some of the challenges she cited in conducting research on elder abuse and neglect include methodology, logistics, and design. Dr. Wolf stressed the need for collaborative partnerships between researchers and service providers in order for any research project to be successful.

Such partnerships can be difficult to forge and sustain, as evidenced by feedback obtained from a Centers for Disease Control-funded program that focused on research in prevention of violence against women. Service providers involved in this program reported that researchers were remote and arrogant, paid insufficient attention to the effect of the research on victims, and failed to solicit input from the practitioners. In order for any research to achieve its aims, there must be a mutually trusting relationship between the researchers and service providers, based upon communication and an acknowledgment of the fundamental differences between practitioners and researchers.

The participants discussed several issues surrounding research on elder abuse and neglect as related to the victims. Research involving human subjects is always a challenge for a number of reasons. Many researchers are uncomfortable dealing with people's pain and suffering. The lack of access to victims was also cited. The greatest challenge in undertaking research of this type is getting approval from institutional review boards (IRBs). Many participants complained that the process was cumbersome and lengthy and, often, placed many restrictions on research, such as mandatory reporting of abuse. Others cited the difficulty in obtaining informed consent, particularly from potential subjects with dementia. To overcome these obstacles, there is a need for greater cross-disciplinary collaborations so that medical, scientific, and legal issues can be addressed at every stage of the process. One example of a procedure that has dealt successfully with these issues was developed for research on human subjects. In that case, a certificate of confidentiality requires researchers to file a report if a human subject is in imminent danger but does not require the precise interview information to be disclosed, thus protecting the researchers from liability and the victim's

privacy. Ultimately, many participants suggested that the IRBs, although a difficult process, were necessary mechanisms to protect both parties.

Lack of funding also was cited as a reason for the dearth of research in elder abuse and neglect. From the little data available, the frequency of elder abuse and neglect is far from clear: thus, a pilot research project would need a large sample size and would need to be conducted over at least 3 years. Participants estimated the cost of such a study at \$2.5 million. Collaborative funding among agencies, such as the Department of Justice and National Institutes of Health, was suggested as the only way to generate the magnitude of funds needed.

Dr. Karl Pillemer, a professor at Cornell University's Department of Human Development, suggested that current and prospective programs must include an evaluation component to assess their efficacy as a condition of receiving funding. Most participants concurred that including a validated evaluative component in ongoing and future projects was a good idea but were concerned that conditioning funding on an evaluative component might be counterproductive.

Participants expressed the need to do something to care for elders being abused and neglected right now, but were very concerned that, without research and scientific evaluations, interventions might be doing more harm than good. For example, Dr. Pillemer cited a study that found that abused or neglected elders in contact with adult protective services (APS) are disproportionately institutionalized and die more frequently.

In addition to the lack of funding, there are few geriatric researchers interested in this issue. Accreditation for geriatric fellowships recently has been changed to 1 year, from 2 or 3 years, which makes it impossible to include a research component. Additionally, many medical schools steer students into more "glamorous" (and well-funded) areas of research. Thus, there was consensus that it was critical to interest students early in elder abuse and neglect.

Perhaps the most important reason cited for the scarcity of research was the lack of a constituency for this issue. Unlike violence against women, which feminists have taken up as an issue, and child abuse, championed by pediatricians and child advocates, elder abuse and neglect has not received a similar public and political response. The participants agreed that progress will follow the research, that research will follow the funding, that elder abuse and neglect must be placed on the national agenda before such funding will materialize, and that prosecutions and public awareness efforts were key to raising the national awareness.

The participants did provide some strategies to work around these obstacles. It was suggested that researchers should apply for funds from smaller foundations to piece together pilot data. The data could form the basis of a research agenda that would attract the larger institutions. Examining healthcare costs and outcomes in relationship to elder abuse and neglect could also provide important information to justify the need for research to foundations and others.

Participants suggested that what little data does exist, from local APS agencies, for example, should be compiled on a national level to provide a more accurate picture of the problem. Before this can be accomplished, however, a national reporting standard needs to be developed and implemented so data can be compared. Also, participants cited the need for descriptive studies, rather than large-scale statistical reviews. Some studies of this type already are under way and can provide the basis for developing hypotheses for larger research projects.

[Back to Top](#)

Preparatory Time for Remarks to the Attorney General

In preparation for their session with Attorney General Janet Reno, participants were asked to identify actions that should be taken to deal more effectively with elder abuse.

Data Collection and Information Sharing

Dr. Rosalie Wolf, executive director of the Institute on Aging at University of Massachusetts Memorial healthcare, echoed the suggestions for establishment of a national forensic center on elder abuse and neglect to be followed later by regional centers.

Dr. Patricia McFeeley, assistant chief medical investigator at the University of New Mexico, highlighted the fact that there already exist crime labs and regional forensic centers that could be used in elder abuse investigations.

Lisa Nerenberg, a consultant in private practice in Redwood City, California, suggested that an online database would help people working in the field to share ideas.

Dr. William Hauda, adult services medical director at the INOVA Fact Center in Falls Church, Virginia, suggested that such a database could be a clearinghouse where people with particular expertise could disseminate information and materials on program design and assist law enforcement with the development of elder abuse cases.

Candace Heisler, a consultant and former prosecutor with the San Francisco District Attorney's Office, said the database should contain information on current programs dealing with elder abuse and neglect from around the country, with contact people and resource materials identified.

Education

Dr. Erik Lindbloom, assistant professor of family medicine at the University of Missouri, stressed the importance of cross-disciplinary education among law enforcement, the medical profession, social workers, and APS to ensure that the necessary information is available for the prosecution of elder abuse and neglect cases.

Dr. Laura Mosqueda, director of geriatrics at the University of California-Irvine Medical Center, pledged to work through the American Geriatric Society to provide more training for service providers and to evaluate the effectiveness of that training.

Ms. Susan Renz, a nurse and consultant with RS Connection Inc., emphasized the need to develop curricula in nursing, social work, and medical schools that focuses more on elder abuse and neglect.

Dr. Carl Eisdorfer, a professor with the University of Miami Department of Psychiatry and Behavioral Sciences, suggested a joint program between physicians and law students involving issues such as involuntary commitment, among other topics. Through the Miami Area Geriatric Center, a national network, Dr. Eisdorfer said he also would work to develop a series of short courses to help put elder abuse and neglect on the national agenda. In addition, he suggested working with residency programs to include elder abuse issues at the "bedside."

Public Policy and Program Development

To institutionalize the momentum of this conference, Dr. Catherine Hawes, a professor at Texas A&M University's School of Rural Public Health, suggested that the Department of Justice establish a permanent task force to deal with elder justice.

Dr. Hawes pledged to designate elder abuse as a priority of the School of Rural Public Health through the Healthy People 2010 program. Through this program, they would identify best practices and assist health departments in addressing the issue.

The importance of developing a constituency around this issue was highlighted by Dr. Karl Pillemer, professor at Cornell University's Department of Human Development. He suggested that prominent figures, such as Attorney General Reno, speak out about elder abuse. Documenting the cost and prevalence of such abuse also might force the issue farther up on the agenda.

And Dr. Hauda noted that the State of Virginia has enacted legislation that will pay for any evaluation of a person who has been a victim of a crime, and that a panel is being formed to establish guidelines for adult victims. The process may take as long as 2 years, but it is an opportunity to obtain existing funding.

Research

Dr. Sidney Stahl, chief, healthcare Organizations and Social Institutions at the National Institute on Aging, suggested conducting an analysis in collaboration with the social research community on elder abuse and neglect regarding interventions that work.

Dr. Hawes described two projects that she is undertaking for the healthcare Financing Administration (HCFA) on complaint investigation and the use of the nurse's aide registry to prevent abuse and neglect. The reports should be published in summer 2001.

According to Ms. Joanne Otto, APS administrator with the Colorado Department of Human Services, the National Association of Adult Protective Services Administrators (NAAPSA) will be conducting a study on APS in the United States. She asked for feedback from participants on the gaps in their States or regions.

[Back to Top](#)

Report to the Attorney General

Introduction:

Marie-Therese Connolly, J.D., Coordinator, Nursing Home Initiative, Senior Trial Counsel, Civil Division, U.S. Department of Justice

Speaker:

The Honorable Janet Reno, Attorney General, U.S. Department of Justice

Noting the groundbreaking nature of the roundtable gathering, Attorney General Janet Reno urged participants to adopt a multidisciplinary approach in dealing with the problems of elder abuse and neglect, and to focus on prevention as well as intervention and the needs of caregivers.

Critically important, she said, is a new attitude toward aging. "I think one of the reasons this area is neglected is because too many people are indifferent to aging," Attorney General Reno said. "But if

they could see what could be done, both in prevention and in preserving life and preserving it in a happy way . . . so that the person still has fun, I think [we could] go a long way."

The Attorney General suggested older people could serve as effective community advocates and as the eyes and ears for community police, so that victims are identified early and receive appropriate intervention and treatment. Also important is the development of expertise in gerontology and a dispersal of knowledge about older people among physicians generally. She noted, for example, the frequent misdiagnosis of abuse and the simple failure to prescribe appropriate medication levels, often because physicians are not familiar with the special needs and circumstances of older people.

She asked participants to ensure that programs are evaluated carefully so that a reliable database of best practices can be developed. Establishing how and why programs work is essential for government officials and advocates who are seeking political support and funding for such programs.

Finally, the Attorney General asked participants: "If you were Attorney General of the United States, what would you do to address the issues that you raised today, and what more can I do to press the issue of elder justice, both while I am here and when I leave here?"

The moderators, Dr. Laura Mosqueda and David Hoffman, provided a brief overview of the issues that the participants had discussed earlier in the day. Dr. Mosqueda emphasized that the science, education, and clinical practice associated with elder abuse and neglect lag far behind those associated with other problems, such as child abuse. Mr. Hoffman highlighted proving medical causation as the biggest issue facing law enforcement and stressed the need for more expert testimony to prove this aspect of elder abuse and neglect. He emphasized the benefits and importance of multidisciplinary teams, described the value of including forensics experts on those teams, and cited the need for more education and research on elder abuse and neglect. Other participants provided the following information and recommendations to the Attorney General.

Research and Education

Dr. Dyer of Baylor College of Medicine stressed the need to promote elder mistreatment education and put forward three goals for this effort. *First*, she emphasized the need to prove the value of such education, suggesting that medical schools be asked to identify at least one elder mistreatment expert in their institution who would serve to emphasize the importance of and advance education on this issue. We need to make the elder death more noteworthy and prosecute alleged perpetrators, particularly of caregiver neglect. *Second*, medical centers must be convinced that elder mistreatment is not solely a social issue but also a medical one, and thus worthy of resources. To accomplish this, Dr. Dyer suggested building incentives through Medicare funding to train more geriatricians, and advancing the recognition of such specialists through increased research grants to enable them to assume leadership positions within medical centers. *Third*, Dr. Dyer suggested a multidisciplinary approach that would have physicians work with a broad spectrum of other types of professionals to increase the knowledge and the effectiveness of treatments.

Dr. Karl Pillemer, professor at the Cornell University Department of Human Development, discussed the need for research on elder mistreatment and abuse. The research agenda must be driven by the real practice needs, Dr. Pillemer stressed, because research and practice inform each other. Especially important are research on risk factors contributing to elder abuse and mistreatment, and on best treatment practices. Additionally, basic research on the prevalence of elder abuse and its associated healthcare, economic, and social costs is needed to determine the scope of resources currently expended in addressing the problem. Funding from a variety of sources is needed to improve evaluations and technology.

Dr. Carl Eisdorfer, chairman of the Department of Psychiatry and Behavioral Sciences at the University of Miami, stressed the need to raise awareness and create a national agenda around the issue of elder abuse and neglect. He suggested using the media, such as radio, to highlight elder abuse, and convening conferences for major foundations to attract increased funding. He also noted the power of the Attorney General's bully pulpit.

Dr. Sidney Stahl, chief of healthcare Organizations and Social Institutions at the National Institute on Aging, noted that the National Institutes of Health (NIH) recently agreed to fund the National Academy of Sciences to examine the available information on elder abuse and to establish a national research agenda on this issue. Dr. Stahl emphasized the need for multiagency funding to carry out this agenda.

Dr. Wendy Wright of San Diego's Children's Hospital offered the perspective of a pediatrician and noted that the field of elder abuse lags far behind the field of child abuse. As a result, few medical experts are available to prosecutors to testify in court. To counter this, Dr. Wright stressed the need to increase the regard for elder life. She stressed the need for increased services for victims and caregivers, and to provide incentives and make it easier for service providers to report on the elder abuse and neglect they encounter. She also suggested the importance of the Internet and telemedicine to increase the level of collaboration and information sharing among service providers.

Community Advocates and Multidisciplinary Teams

Attorney General Reno emphasized the need to connect prevention and service delivery and supported the use of community advocates who are less costly and sometimes more effective than lawyers in getting services for victims. She cited the recently announced Healthy Children-Safe Schools grants, a collaboration among the Departments of Health and Human Services, Justice, Labor, and Education, as a model of interagency collaboration that should be applied to the issue of elder mistreatment and abuse.

Dr. Mark Lachs, co-chief of geriatrics and gerontology at the Cornell University Weill Medical College, offered that community advocates also should be recruited from the older population, noting, "[T]here is an enormous untapped resource of older adults who could serve in this capacity." Noting how few geriatricians there are in this country, Dr. Lachs also emphasized the need to train family practitioners in elder medicine so they can better treat elder patients and identify potential abuse and neglect.

Dr. Rosalie Wolf, executive director of the University of Massachusetts Memorial healthcare Institute on Aging, stressed the need to include older people in the agenda. Also, she identified the need to "raise the index of suspicion among physicians, medical examiners, [and] criminal justice personnel" on elder abuse, which requires increased cross-training and collaborations among these different disciplines. She again stressed the need for increased resources not only for research but also to allow professionals to serve on multidisciplinary teams.

Dr. Patricia McFeeley, assistant chief medical investigator at the University of New Mexico, urged that forensic pathologists should be the primary people in elder mistreatment multidisciplinary teams, in that they are best able to recognize patterns of abuse, are able to determine the severity of injuries, and are experienced with the legal system and can testify in court.

Randolph Thomas, a police officer and law enforcement instructor with the South Carolina Department of Safety, emphasized the important role that community police officers play and stressed the need to devote increased resources for training to enable them to respond more effectively to the wide range of issues, including drugs, violence, and child, elder, and spousal abuse. As members of a multidisciplinary team, these community police officers (and other team

members) benefit from the expertise of the different members of the team and learn how other disciplines approach this issue.

Caregivers

Dr. Mosqueda reported that the focus of discussion had been on victims, rather than on issues of perpetrators. She suggested that there are "good guy" and "bad guy" perpetrators, and that the appropriate response differed depending on the type of perpetrator.

Dr. Pillemer agreed, stressing that elder abuse is not monolithic and neither are the perpetrators. Many "good guy" perpetrators are caregivers under tremendous stress and lacking support. Dr. Pillemer suggested that there needs to be a whole range of support programs to address the needs of these caregivers and reduce the likelihood of abuse.

Dr. Eisdorfer noted that very often physicians spend more time addressing the medical needs of caregivers who suffer from depression and other stress-related disorders than they do tending to their older patients. He called for an increased emphasis and more funding to attend to the unique needs of those who care for older people.

In thanking the participants for their feedback, Attorney General Reno commented, "I have seen the magic that you can bring to somebody's life that seemed done and over with, and I have seen what you can do in terms of preventing problems, and I would like to work with you in every way I can to let people know that old age can be fine."

[Back to Top](#)

Wrap-up and Next Steps

Moderators:

David R. Hoffman, J.D., Assistant United States Attorney, Eastern District of Pennsylvania

Laura Mosqueda, M.D., Director of Geriatrics, Associate Clinical Professor of Family Medicine, University of California-Irvine Medical Center

Participants sought ways to sustain the enthusiasm and momentum generated at the roundtable when they return to their home institutions.

Dr. Sanders of the University of Arizona and Dr. Dyer of the Baylor College of Medicine suggested developing an agenda with timelines, to be forwarded to all participants, in order to avoid returning to the status quo.

Several participants suggested creation of centralized repositories of information and mechanisms by which they could continue to communicate with each other, for example by listserv. Another suggestion was the creation of a national database that would include a directory of experts, as well as resources for training materials and texts. Marie-Therese Connolly of the Department of Justice noted that the ABA Commission on Legal Problems of the Elderly maintains an elder abuse listserv.

Finally, several of those who observed the roundtable discussion made these suggestions:

- Mary Ellen Courtright from the Archstone Foundation noted the availability of program funding from several sources, including Grantmakers in Aging, a group of 150 foundations that focus primarily on aging.

- Joanne Ivancic from the U.S. Senate Special Committee on Aging suggested that efforts dealing with elder abuse and neglect should be institutionalized at the U.S. Department of Justice.
- Nancy Coleman from the American Bar Association noted the use of cross-disciplinary models for education now used at the University of Oklahoma and the University of Michigan and suggested that similar efforts could be applied to the study of elder justice.
- Donna Cohen from the University of South Florida suggested that best practices should be catalogued so they can be more easily shared. She noted a successful elder justice center established within the Florida court system that might provide useful models for others.

[Back to Top](#)

Agenda

U.S. Department of Justice Elder Justice: Medical Forensic Issues Relating to Elder Abuse and Neglect

Roundtable Discussion October 18, 2000

- | | |
|-------------------------|--|
| 8:15 - 9:00 a.m. | <i>Continental Breakfast and Registration</i> |
| 9:00 - 9:15 a.m. | <i>Welcome and Introduction</i>
The Honorable Daniel Marcus, Associate Attorney General, U.S. Department of Justice
D. Jean Veda, J.D., Deputy Associate Attorney General, U.S. Department of Justice |
| 9:15 - 10:15 a.m. | Detection and Diagnosis: <i>What Are the Forensic Markers for Identifying Physical and Psychological Signs of Abuse and Neglect? What is the current medical "state of the art?" Is there a difference in forensic markers for community abuse and neglect versus institutional abuse and neglect? How do we distinguish between abuse and neglect and conditions that result from other causes? How do we determine when explanations are contrived to conceal abuse and neglect? How well do physicians detect elder abuse and neglect?</i> |
| 10:15 - 10:30 a.m. | <i>Break</i> |
| 10:30 - 11:30 a.m. | Application of the Forensic Science: <i>Integrating Medical Forensic Evidence With Law Enforcement</i>
How should healthcare and law enforcement professionals work together in enhancing prosecution of cases involving elder abuse or neglect? What is the role of the medical examiner, the attending physician, the emergency room team, and others? What is the role for multidisciplinary teams? What can we learn from the child abuse and domestic violence areas? What type of forensic center(s) or forensic capability would be the most useful and feasible in diagnosing and pursuing cases of abuse and neglect? |
| 11:30 a.m. - 12:30 p.m. | Education: <i>What Training Is Needed for healthcare and Law Enforcement Professionals on Forensic Elder Abuse and Neglect Issues?</i>
What topics should be taught so that healthcare professionals |

effectively serve as forensic evaluators of elder abuse and neglect? Does the variation from state to state of elder abuse reporting laws make education difficult and/or confusing? How do we encourage medical, nursing, social work, and public health schools to place elder abuse and neglect on their curricula? How do we encourage practicing physicians, psychologists, nurses, and other public health officials to develop an expertise in this area?

12:30 - 1:00 p.m.

Break - Pick up box lunch

1:00 - 1:50 p.m.

Research: Setting the Research Agenda to Improve the Forensic Science of Elder Abuse and Neglect

Where should research on elder abuse and neglect, and the development of forensic evidence thereof, be concentrated? What are the current gaps in medical knowledge? How should we prioritize the research agenda? How do we assure that the needed research occurs? What are the barriers to conducting the needed research? How can those barriers be removed or overcome? Is the failure to report elder abuse and neglect—by physicians and others—a problem in understanding the dimensions of the problem?

1:50 - 2:20 p.m.

Preparatory Time for Remarks

2:20 - 2:30 p.m.

Break

2:30 - 4:00 p.m.

Report Back to the Attorney General: The Honorable Janet Reno, Attorney General of the United States

What have we learned from today's sessions? What are the challenges, success, and recommendations identified by participants? What will roundtable participants take back to their institutions/clinics/practices to further development of this field?

4:00 - 4:30 p.m.

Wrap-Up and Next Steps

[Back to Top](#)

Participants

Ann Burgess, R.N., D.N.Sc., C.S., F.A.A.N.

Professor of Psychiatric
Mental Health Nursing
University of Pennsylvania
School of Nursing

Donna Cohen, Ph.D.

Professor
Department of Aging and Mental Health
University of South Florida

Kerry P. Burnight, Ph.D.

Assistant Clinical Professor
University of California-Irvine
College of Medicine

Marie-Therese Connolly, J.D.

Coordinator, Nursing Home Initiative
U.S. Department of Justice

**Carmel Bitondo Dyer, M.D., A.G.S.F.,
F.A.C.P.**

Associate Professor of Medicine
Baylor College of Medicine
Director, Geriatrics Program
Harris County Hospital District

Carl Eisdorfer, Ph.D., M.D.

Professor and Chairman
University of Miami
Dept. of Psychiatry and Behavioral Sciences

Charles W. Gambrell, Jr., J.D.
Assistant Deputy Attorney General
South Carolina Attorney General's Office
Director
South Carolina Medicaid Fraud Control Unit

William E. Hauda II, M.D.
Adult Services Medical Director
INOVA Fact Center

Catherine Hawes, Ph.D.
Professor
Department of Health Policy & Management
School of Rural Public Health
Texas A&M University
System Health Science Center

Candace J. Heisler, J.D.
Consultant and Trainer
San Francisco District Attorney's Office
(Retired)

David R. Hoffman, J.D.
Assistant United States Attorney
Eastern District of Pennsylvania

Ian Hood, M.D., J.D.
Deputy Medical Examiner
Philadelphia Medical Examiner's Office

Mark S. Lachs, M.D., M.P.H.
Co-Chief, Geriatrics and Gerontology
Weill Medical College
Cornell University

Erik Lindbloom, M.D., M.S.P.H.
Assistant Professor of Family Medicine
University of Missouri

Patricia J. McFeeley, M.D.
Assistant Chief Medical Investigator
Office of the Medical Investigator
University of New Mexico
Health Sciences Center

Laura Mosqueda, M.D.
Director of Geriatrics
Associate Clinical Professor of
Family Medicine
U.C.I. Medical Center

Lisa Nerenberg, M.S.W., M.P.H.
Consultant-Private Practice

Joanne Marlatt Otto, M.S.W.
Adult Protective Services Administrator
Colorado Department of Human Services

Gregory J. Paveza, Ph.D., M.S.W.
Associate Professor
University of South Florida
School of Social Work

Thomas H. Peake, Ph.D., A.B.P.P.
Professor of Psychology
Florida Institute of Technology

Karl Pillemer, Ph.D.
Professor
Department of Human Development
Cornell University

Susan M. Renz, M.S.N., R.N., C.S.
Medical/Legal Geriatric Consultant
RS Connection Inc.

Arthur Sanders, M.D.
Professor
Division of Emergency Medicine
University of Arizona

Sidney M. Stahl, Ph.D.
Chief, healthcare Organizations &
Social Institutions
National Institute on Aging
National Institutes of Health

Randolph W. Thomas, M.A.
Law Enforcement Instructor
South Carolina Department of Public Safety
Criminal Justice Academy

D. Jean Veta, J.D.
Deputy Associate Attorney General
U.S. Department of Justice

Rosalie S. Wolf, Ph.D.
Executive Director, Institute on Aging
University of Massachusetts Memorial
healthcare

Wendy Wright, M.D.
Children's Hospital

Participant Profiles

Ann Wolbert Burgess, R.N., D.N.Sc., C.S., F.A.A.N., is a Professor of Psychiatric Mental Health Nursing at the University of Pennsylvania School of Nursing. She received her bachelor's and doctoral degrees from Boston University and her master's degree from the University of Maryland. Dr. Burgess, with Lynda Lytle Holmstrom, cofounded one of the first hospital-based crisis intervention programs for rape victims at Boston City Hospital in the mid-1970s. One of the current outcomes of the work with rape victims has been the development of the forensic nursing role of Sexual Assault Nurse Examiner (SANE). Dr. Burgess has conducted many projects. She has been principal investigator of research projects on the use of children in pornography; heart attack victims and return to work; sexual homicide and patterns of crime scenes; possible linkages between sexual abuse and exploitation of children, juvenile delinquency and criminal behavior; children as witnesses in child sexual abuse trials; AIDS, ethics and sexual assault; and infant kidnapping. Dr. Burgess has written 9 textbooks, 12 books, coauthored more than 135 articles/chapters, and 6 monographs. Her current research is on patterns of trauma in elderly rape victims and the motivation of gerophiles. Dr. Burgess maintains a private clinical practice in Massachusetts. In addition, she serves as an expert witness in criminal and civil suits for the government, plaintiff, and defense. Dr. Burgess has served on the American Nurses Association (ANA) Council of Specialists in Psychiatric Mental Health Nursing Executive Committee, the ANA Cabinet of Nursing Research, and the American Academy of Nursing's Governing Council. She has served as chair of the first Advisory Council to the National Center for the Prevention and Control of Rape of the National Institute of Mental Health, 1976-80. Also, she was a member of the 1984 U.S. Attorney General's Task Force on Family Violence and was a member of the planning committee for the 1985 Surgeon General's Symposium on Violence. She served on the National Institute of Health National Advisory Council for the Center for Nursing Research, 1986-88, and was a member of the 1990 Adolescent Health Advisory Panel to the Congress of the United States Office of Technology Assessment. She was chair of the National Institutes of Health AIDS and Related Research Study Section (ARRR 6), 1992-94. In addition, Dr. Burgess was elected to the National Academy of Sciences Institute of Medicine in October 1994 and chaired the 1996 National Research Council's Task Force on Violence Against Women. Currently, she serves as the research partner to the National Sexual Assault Resource Center that is directed by the Pennsylvania Coalition Against Rape in Enola, Pennsylvania, and funded by the Centers for Disease Control and Prevention.

Kerry Burnight, Ph.D., received her doctorate in Gerontology and Public Policy from the University of Southern California's Andrus Gerontology Center. For the past 11 years, Dr. Burnight has been conducting gerontological research for academic, private, and government organizations. She is currently an Assistant Clinical Professor at the University of California-Irvine, College of Medicine, where she conducts research on the abuse and neglect of older adults. Dr. Burnight also served on the faculty of the California Medical Training Center, where she helped develop and teach courses on the recognition, reporting, and documentation of elder abuse. Dr. Burnight is coinvestigator of a project that provides interdisciplinary medical evaluation and consultation to the social service, law enforcement, and legal communities.

Marie-Therese Connolly, J.D., a Senior Trial Counsel in the Civil Division, is the coordinator of the Department of Justice Nursing Home Initiative. In that capacity, she coordinates the Department's internal efforts and works closely with the Department of Health and Human Services and other national, State, and local healthcare, public safety, regulatory, social service, and law enforcement entities on a wide variety of nursing home and elder justice-related issues and cases. Ms. Connolly joined the Department in 1986 following a clerkship with the Honorable Paul H. Roney of the United States Court of Appeals for the Eleventh Circuit. Before coordinating the Nursing Home Initiative, Ms. Connolly handled a variety of primarily civil fraud cases; most recently she was lead counsel in

United States ex rel. Zissler v. University of Minnesota, settled in late 1998 for \$32 million, which made new law in several areas.

Carmel Bitondo Dyer, M.D., graduated from Baylor College of Medicine in 1988. She is board certified in Internal Medicine and Geriatrics and has been the Director of the Geriatrics Program at the Harris County Hospital District since completing her postgraduate training in 1993. She is currently an Associate Professor of Medicine at Baylor College of Medicine, and her clinical interests include care of the elderly poor, elder mistreatment, dementia, delirium, depression, and geriatric assessment. Her research and publications are in the area of elder neglect and the interdisciplinary approach to abused or neglected elders. Dr. Dyer is co-director of the Texas Elder Abuse and Mistreatment Institute.

Carl Eisdorfer, Ph.D., M.D., received his doctorate from New York University, his M.D. from Duke University, and his Certificate in Health Systems Management from Harvard University. He directed the Duke University Center for Aging and Human Development and the Institute on Aging at the University of Washington, where he also chaired the Department of Psychiatry and Behavioral Sciences. He has served as Senior Scholar in Residence at the IOM of the National Academy of Science in Washington, D.C., and President and CEO of Montifore Medical Center in New York. In 1986, he joined the faculty at the University of Miami, where he is Professor and Chairman of the Department of Psychiatry and Behavioral Sciences and Director of the University of Miami Center on Adult Development and Aging. He has served on the Federal Council on Aging, the Council of the N.I.A., and the Commission to Restructure the V.A. Health Systems for the 21st Century. He is the recipient of numerous awards for his work in aging and mental health, including the Allied Signal Award, the Founder Award of the Alzheimer's Disease Society, and the Menniger Award of the American College of Physicians. Dr. Eisdorfer has served as President of several national professional organizations, including the American Society on Aging, the Gerontological Society of America, and the American Federation for Aging Research. He is the author and editor of more than 300 research and professional publications, principally on aging, healthcare policy, Alzheimer's disease, psychoneuroimmunology, and the impact of caregiving for chronically ill relatives.

Charles W. "Bill" Gambrell, Jr., J.D., received his B.S. degree in Mathematics from the University of South Carolina in 1972 and his J.D. degree from the University of South Carolina School of Law in 1977. Mr. Gambrell is Assistant Deputy Attorney General in the Office of the Attorney General for South Carolina and the Director of the South Carolina Medicaid Fraud Control Unit. Prior to joining the Attorney General's Office in 1983, Mr. Gambrell was a partner in the law firm of King and Gambrell, P.A., in Columbia, South Carolina. Mr. Gambrell is also Vice President of the National Association of Medicaid Fraud Control Units, Chairman of the Patient Abuse Working Group of the National Association of Medicaid Fraud Control Units, and an editor of *A Guide for Investigating and Prosecuting Patient Abuse, Neglect and Mistreatment in Nursing Homes*, published by the National Association of Medicaid Fraud Control Units. Mr. Gambrell has served on a number of law enforcement committees and has prosecuted "white collar" criminal cases, violent crimes, and drug offenses during his career at the Attorney General's office.

William E. Hauda II, M.D., is an Attending Emergency Physician at INOVA Fairfax Hospital, Department of Emergency Medicine. He graduated from the University of Wisconsin Medical School in May of 1992 and completed his residency in Emergency Medicine at Johns Hopkins University in 1995. He is an Assistant Clinical Professor, Department of Emergency Medicine, George Washington University School of Medicine. He holds an appointment as Clinical Instructor, Department of Pediatrics, University of Virginia, School of Medicine. Currently, he is the Operational Medical Director for the Fairfax County Police Helicopter Unit and a Medical Examiner for the City and County of Fairfax, Virginia.

Catherine Hawes, Ph.D., is a Professor in the Department of Health Policy and Management, School of Rural Public Health at Texas A&M University Health Science Center. She is also Director of the Southwest Rural Health Research Center at Texas A&M. Dr. Hawes has 25 years of experience in research, teaching, and policymaking at the Myers Research Institute, Research Triangle Institute, Duke University, and as director of a State legislative commission, Medicaid fraud investigator, and staff investigator for the U.S. Senate Special Committee on Aging. She has led research projects in all areas of long-term care. Current projects include one to examine the investigation of complaints about nursing home quality and to make recommendations to healthcare Financing Administration (HCFA) and the States about how to improve the process (HCFA); a study of how to prevent abuse and neglect of nursing home residents (HCFA); a study of State use of enforcement remedies to ensure nursing home quality (Retirement Research Foundation); and a study on quality measurement in assisted living and residential care (AHRQ). Some of her prior studies include a *National Study of Assisted Living for the Frail Elderly* (ASPE); *Evaluation of the Senior Companion Homebound Elderly Demonstrations* (ACTION); *Analysis of the Effect of Regulation on Board and Care Home Quality* (DHHS/ASPE); and *Development of the Nursing Home Resident Assessment Instrument-RAI/MDS* (HCFA). Within these projects, Dr. Hawes' work has focused on such topics as assessment, quality measurement, reimbursement, quality assurance, regulatory effectiveness, and the relationship between cost and quality. She has published widely on these topics in such journals as the *Gerontologist*, *Journal of the American Geriatrics Society*; the *American Journal of Public Health*; *Journals of Gerontology: Psychological Sciences*; *Age and Aging*; *Generations*; *Journals of Gerontology: Medical Sciences*; and the *Journal of the American Medical Association*. She has also served on a number of national advisory committees, including the Institute of Medicine's Committee on Nursing Home Regulation.

Candace Heisler, J.D., was a San Francisco Assistant District Attorney for more than 25 years prior to her retirement last July. As a prosecutor, she headed the Domestic Violence Unit that oversaw the prosecution of domestic violence and elder abuse cases. She has edited four judicial curricula and a prosecution manual on domestic violence cases. She has authored a number of articles that have been published in *The Journal of Elder Abuse and Neglect* and in various publications produced by the California District Attorney's Association. Also, she has helped develop four telecourses on domestic violence and elder abuse for California law enforcement and courses on domestic violence for law enforcement first responders and investigators. She is developing new courses for Field Training Officers and Dispatchers. She teaches courses in domestic violence and elder abuse for California law enforcement, Victim Witness Program advocates, and prosecutors. In addition, she is an officer for the National Committee for the Prevention of Elder Abuse, a member of the California Violence Against Women STOP Task Force; has served on the Texas Medical Association Blue Ribbon Panel on family violence; and has received many awards, including the California District Attorney's Association Career Achievement Award and the California Governor's Victim Services Award. She is also an Assistant Adjunct Professor of Law at the University of California's Hastings College of Law.

David R. Hoffman, J.D., is a graduate of the University of Pittsburgh and the University of Pittsburgh School of Law. He is currently an Assistant United States Attorney in the Eastern District of Pennsylvania. He prosecutes healthcare fraud matters, both civilly and criminally. Mr. Hoffman brought the first balance billing action against a physician, the first healthcare RICO prosecution in the district, and has been successful in prosecuting physicians, pharmacists, drug manufacturers, and nursing homes. Mr. Hoffman has successfully prosecuted large nursing home chains and several long-term care facilities for failure to provide adequate care to their residents. These prosecutions resulted in Consent Orders mandating, among other requirements, corporate compliance programs, diabetes monitoring and nutrition, and wound care standards that must be met and which are monitored by the United States Attorney's Office. Mr. Hoffman has also successfully prosecuted quality of care cases in the boarding home arena. He was awarded the 1996 Director's Award from the United States Department of Justice Executive Office for United States Attorneys for his work in protecting the elderly from abuse and neglect. He also was awarded the 1999 Department of Health and Human Services Inspector General's Integrity Award. Prior to joining the United States

Attorney's Office, Mr. Hoffman served as Chief Counsel for the Pennsylvania Department of Aging. Before joining the Department of Aging, Mr. Hoffman was an Assistant District Attorney in Philadelphia and also served as judicial law clerk to the Honorable Anthony J. Scirica in State and Federal court. He is a lecturer in Law/Clinical Instructor for Temple University's School of Law and has lectured at the University of Pennsylvania School of Law and Villanova University School of Law on healthcare issues affecting the elderly.

Ian Hood, M.D., J.D., graduated from medical school in New Zealand and completed a residency in pathology at McMaster University in Ontario, Canada, becoming board certified in Anatomic and Clinical Pathology in the United States and Anatomic and General Pathology in Canada. He trained in Forensic Pathology at the Wayne County Medical Examiner's Office in Detroit, Michigan, and after becoming board certified in that specialty joined the staff there. He is currently a Coroner's Pathologist for Chester, Montgomery, and Bucks Counties in Pennsylvania and the Deputy Medical Examiner in Philadelphia. Dr. Hood has also graduated from Temple Law School and is a member of the Bar in Pennsylvania. He has participated in several investigations of neglect and abuse of elderly nursing home residents, including prosecutions for homicide by caregivers. He has also been active in the monitoring and prevention of deaths of the elderly and infirm from heat stress in periods of hot weather. He is a member of the Pennsylvania Attorney General's Medicolegal Advisory Board on Elder Abuse and Neglect.

Mark S. Lachs, M.D., M.P.H., is a graduate of the University of Pennsylvania and the New York University School of Medicine. He completed a residency in Internal Medicine at the hospital of the University and is board certified in Internal Medicine. In 1988, he became a Robert Wood Johnson Clinical Scholar at Yale where he also earned a master of public health degree in Chronic Disease Epidemiology and added qualifications in Geriatric Medicine from the American Board of Internal Medicine. He spent 4 years on the Yale Faculty before coming to Cornell to lead the Geriatrics Program. Currently, Dr. Lachs is the Director of Geriatrics for the New York Presbyterian Health System, co-chief of the Division of Geriatric Medicine and Gerontology at the Weill Medical College of Cornell University, and an Associate Professor of Medicine at the college. Dr. Lachs' major area of interest is the disenfranchised elderly, and he has published widely in the areas of elder abuse and neglect, adult protective services, the measurement of functional status, ethics, and the financing of healthcare. He has lectured internationally on these topics. His honors and awards include an American College of Physicians Teaching and Research Scholarship, a National Institute on Aging Academic Leadership Award, and a Paul Beeson Physician Faculty Scholarship, the country's preeminent career development award in aging. He is also the recipient of ROI funding from the National Institutes of Health to study the impact of crime on the physical and emotional health of older adults. In January, Dr. Lachs became the first director of the Cornell Center for Aging Research and Clinical Care (CARCC), a multidisciplinary group of scientists, clinicians, and educators who seek to speed scientific advances from bench to bedside, teach geriatric medicine to physicians-in-training at all levels, and create a trans-institutional community of gerontologists at Cornell. His service includes membership on an Institute of Medicine Committee to address the training needs of health professionals in family violence and participation in the AMA/ABA joint conference on family violence. He also sits on the board of the American Federation for Aging Research. Dr. Lachs' greatest passion is practicing and teaching geriatric medicine in the outpatient, hospital, long-term care, and housecall setting. He maintains a practice at the Irving Wright Center on Aging, a community-based ambulatory care practice for older adults that he founded with Dr. Ronald Adelman in 1998. A unique social experiment intended to provide seamless medical and supportive services for older people, it is also home to the Burden Center for the Aging and the Hebrew Home for the Aged's ElderServe Program. He and Dr. Adelman also lead a student interest group in Geriatric Medicine at Cornell.

Erik Lindbloom, M.D., M.S.P.H., is an Assistant Professor of Family Medicine at the University of Missouri-Columbia. Dr. Lindbloom received his M.D. from Northwestern University and his residency training from the University of California-San Diego. He recently completed a 3-year fellowship in geriatric medicine and research at the University of Missouri. He is currently collaborating with the

State of Missouri's Division of Aging on a study estimating the incidence of fatal elder mistreatment in the State. His areas of interest include elder mistreatment, older adults with poor access to healthcare, and evidence-based medicine. He serves on the Board of Directors of the North American Primary Care Research Group and the Research Committee of the Society of Teachers of Family Medicine. Dr. Lindbloom has co-authored a recently published book, *Challenging Diagnoses*, and he is an Assistant Editor for the Journal of Family Practice. He is a practicing family physician and geriatrician at a federally qualified health center in Columbia, Missouri.

Patricia J. McFeeley, M.D., received her undergraduate education at Ohio Wesleyan University, Delaware, Ohio, and earned her M.D. degree from the University of New Mexico School of Medicine, Albuquerque, New Mexico. She completed her residency in pathology at the University of New Mexico School of Medicine, with 1 year spent in specialty training in pediatric pathology at Denver Children's Hospital. She completed postdoctoral fellowship training in forensic pathology at the Office of the Medical Investigator, where she is currently Assistant Chief Medical Investigator for the State of New Mexico. Dr. McFeeley is certified in anatomic and forensic pathology by the American Board of Pathology. She is the immediate past President of the American Academy of Forensic Sciences. She serves on the board of the New Mexico chapter of the National Sudden Infant Death Syndrome Foundation and belongs to the National Association of Medical Examiners (past board of directors member), the American Medical Association, and the American Society of Clinical Pathologists. She was a member of the Pathology Study Panel of the NICHD Cooperative Epidemiologic Study of SIDS Risk Factors and was a reviewer for the Chicago Infant Mortality Study. Dr. McFeeley has been a consultant to the Centers for Disease Control Medical Examiner/Coroner Information Sharing Project and is currently a member of the United Network for Organ Sharing (UNOS) Medical Examiner and Coroner Task Force. She is a sponsor/member of the New Mexico Maternal Mortality Review (MMR) and the Child Fatality Review (CFR). Her research interests include pediatric forensic pathology, including Sudden Infant Death Syndrome (SIDS), Time of Death, and Death Scene Investigation.

Laura Mosqueda, M.D., is a board-certified geriatrician and family physician. Dr. Mosqueda is the Director of Geriatrics at the University of California-Irvine, College of Medicine, where she is also an Associate Professor of Clinical Family Medicine. Dr. Mosqueda served as the co-chief of the Elder Abuse Domain of the California Medical Training Center, where she was responsible for creating and implementing courses designed to train physicians and healthcare professionals in the medical forensic aspects of elder abuse. She also serves as the codirector of the Rehabilitation Research and Training Center on Aging With a Disability, at Rancho Los Amigos Medical Center. Dr. Mosqueda is the principal investigator of a 3-year project to create, implement, and evaluate an interdisciplinary elder abuse medical response team. This team works closely with Adult Protective Services, law enforcement, and the district attorney's office in addressing the abuse and neglect of older adults and adults with disabilities.

Lisa Nerenberg, M.S.W., M.P.H., is a consultant in private practice. Until recently, she directed the San Francisco Consortium for Elder Abuse Prevention at the Goldman Institute on Aging, a program that has been acknowledged as a national model of coordinated service delivery. Within this capacity, she designed, tested, and replicated a variety of new programs and services, including the widely replicated multidisciplinary elder abuse case review team, culturally specific outreach campaigns, a shelter, counseling program, and a support group for victims. She coordinates the Affiliate Program of the National Committee for the Prevention of Elder Abuse (NCPEA), a network of 18 State and local coalitions across the United States and Great Britain, and edits NCPEA's newsletter, *Nexus*, which focuses on cutting-edge issues in elder abuse prevention. She also produces technical assistance materials for the National Center on Elder Abuse. Ms. Nerenberg has conducted hundreds of training sessions on elder abuse and neglect, given keynote addresses, and delivered presentations at dozens of national professional forums. She has authored numerous chapters, articles, and manuals on a variety of topics related to elder abuse, including coalition building, prosecution of abuse cases, undue influence, financial abuse, victim services, culturally specific outreach, older battered women, and multidisciplinary teams. She recently guest edited

issues of the *Journal of Elder Abuse & Neglect*, and *Generations*, a publication of the American Society on Aging. She has developed training and curricula for State units on aging and adult elder abuse for police officers under contract to the Police Executive Research Forum. In addition, she has testified before subcommittees of the United States Senate and provided consultation and technical assistance to dozens of local and State level organizations across the United States and Canada.

Joanne Marlatt Otto, M.S.W., received her Master of Social Work degree from the University of Denver. She has worked in the field of Adult Protective Services for more than 20 years. Since 1986, she has served as the Adult Protective Services Administrator for the Colorado State Department of Human Services, Aging and Adult Services Division. In that capacity, she develops State policy, drafts legislation, designs and implements research projects, and conducts statewide training. Ms. Otto is the past president of the National Association of Adult Protective Services Administrators (NAAPSA) and was a partner in the National Center on Elder Abuse from 1998 to 2000. Through her association with NAAPSA, she has participated in designing and conducting national studies of Adult Protective Services and has given presentations to a wide variety of national organizations, including the Administration on Aging, the Institute of Medicine, and the U.S. Department of Justice. Since 1997, Ms. Otto has been the editor of *Victimization of the Elderly and Disabled*, a bimonthly publication. Her most recent publication, "The Role of Adult Protective Services in Addressing Abuse," appeared in the summer 2000 issue of *Generations*.

Gregory Paveza, Ph.D., M.S.W., received his B.A. from Lewis College in 1969, his M.S.W. from the University of Hawaii in 1973, and his Ph.D. in Public Health Sciences (Psychiatric Epidemiology) in 1986 from the School of Public Health at the University of Illinois at Chicago. Dr. Paveza is currently an Associate Professor in the School of Social Work and one of the founding faculty in the interdisciplinary Ph.D. in Aging Studies Program at the University of South Florida, located in Tampa, Florida. He has been a clinical social work practitioner, a social service agency administrator, and a health sciences researcher. He is currently an active university researcher and educator. His research interests include issues related to the social consequences of caregiving and Alzheimer's disease, including his specific interest in elder mistreatment in these families. Also, he has a general interest in elder mistreatment in all of its forms and its impact on the broader aging community. He is currently a member of the Institute of Medicine/National Research Council Committee on the Training Needs of Health Professionals to Respond to Family Violence, and a member of the Leadership Council of the Mental Health and Aging Network of the American Society on Aging. He has published extensively on issues related to geriatric assessment; on the caregiving consequences of Alzheimer's disease, including the cost of providing community-based care; and on elder mistreatment.

Thomas H. Peake, Ph.D., A.B.P.P., is currently Professor and Associate Dean of the School of Psychology at Florida Institute of Technology (Melbourne) and adjunct Professor at Florida Mental Health Institute Department of Aging (University of South Florida, Tampa). Licensed in Florida, Virginia, Michigan, and Great Britain, he has trained health professionals at Eastern Virginia and Michigan State medical schools and practiced clinical and medical psychology for more than 20 years. He is the Psychology Director of one of Florida's 13 State-supported Memory Disorder Clinics. His publications and practice areas include clinical training, psychotherapy, medical psychology, family therapy, and problems in healthy aging. His most recent publications related to this conference include the following: (1) Peake, T., Oelschlager, J. and Kearns, D. (2000). "Elder Abuse: Families, Systems, Causes and Interventions." In Kaslow, F. (ed). *Handbook of Couple and Family Forensics*. New York: Wiley. (2) Peake, T. (1998). *Healthy Aging, Healthy Treatment: The Impact of Telling Stories*. Westport, CT: Praeger/Greenwood. (3) Peake, T. (2000). *Brief Psychotherapies* (Second Printing). New York: Jason Aronson.

Karl Pillemer, Ph.D., is Professor of Human Development at Cornell University, where he also directs the Cornell Gerontology Research Institute, one of five Edward R. Roybal Centers on Applied

Gerontology established nationwide by the National Institute on Aging. Over the past 20 years, he has conducted an extensive program of basic and intervention research on the abuse and neglect of elderly persons. In the area of family abuse of the elderly, he conducted the first large-scale prevalence study of this phenomenon, which interviewed more than 2,000 senior citizens in the greater Boston area. This study provided the first scientific estimates of the prevalence of elder abuse. With Mark Lachs, he has examined the role of elder abuse as a cause of mortality, using longitudinal epidemiological survey data. He also used survey techniques to conduct the first major survey of abuse and neglect in nursing homes, conducted in the State of New Hampshire. Since that time, he has replicated the study in the Philadelphia area and surveyed nursing home staff in several other States on issues of abuse and neglect. Dr. Pillemer has been involved in intervention programs to prevent abuse and conducted the evaluation of the "Ensuring an Abuse-Free Environment" program, in collaboration with the Coalition of Advocates for the Rights and Interests of the Elderly (Philadelphia). Dr. Pillemer's books on this topic include *Elder Abuse: Conflict in the Family* (Auburn House) and *Helping Elderly Victims: The Reality of Elder Abuse* (Columbia University Press), both with Rosalie Wolf. He is currently working on a practical book for nursing homes entitled *Abuse-Proofing Your Facility*. Dr. Pillemer's work on elder abuse has been published in such journals as *The Gerontologist*, *Journal of Health and Social Behavior*, *New England Journal of Medicine*, *Journal of the American Medical Association*, *Research on Aging*, and *Journal of Elder Abuse and Neglect*. He was a member of the Panel on Research on Anti-Social, Aggressive, and Violent Behavior convened by the National Institutes of Health. Dr. Pillemer's current work also focuses on improving the quality of care provided by nursing home staff. He created and evaluated *Partners in Caregiving*, a model training program that promotes cooperation and communication among family members and nursing home staff, which won a national Best Practice Award from the National Center for Human Resources and Aging. He is also working on improving the recruitment and retention of frontline long-term care workers. His books on this topic include *Solving the Frontline Crisis in Long-Term Care*, and *The Nursing Assistant's Survival Guide*. He has a long history of involvement in practice and policy issues relating to frontline long-term care workers and is the editor of *Nursing Assistant Monthly*, an educational newsletter for frontline staff used in more than 2,000 nursing homes nationwide. Dr. Pillemer is a founding member of the National Committee for the Prevention of Elder Abuse.

Susan M. Renz, M.S.N., R.N., C.S., received her master's degree as a Gerontologic Nurse Clinician from the University of Pennsylvania, prepared as a nurse practitioner. She is currently working with the U.S. Department of Justice as a Federal monitor and serves as Project Director for Siderail Reduction Study conducted by the University of Pennsylvania School of Nursing. Ms. Renz is a member of the Attorney General's Medical/Legal Advisory Board for Abuse and Neglect. She has more than 14 years of experience working in long-term care. Also, she has worked as a clinician, director of nursing, and regional director of health services in a variety of long-term care facilities. She has provided consultation to facilities on fall management, restraint, reduction, survey preparedness, and pharmacological management.

Arthur B. Sanders, M.D., graduated from Cornell Medical School and received training at the University of Arizona. Presently, Dr. Sanders is a Professor in the Division of Emergency Medicine at the University of Arizona College of Medicine. His primary academic interests are cardiopulmonary resuscitation, geriatric emergency medicine, and biomedical ethics. He is a past president of Society for Academic Medicine (SAEM). He served as chair of the Geriatric Emergency Medicine Task Force for SAEM and was principal investigator for a grant from the John A. Hartford Foundation. He edited a book entitled *Emergency Care for the Elder Person* for the Task Force and an accompanying teaching manual. Dr. Sanders has served in a number of other positions, including vice-chair of the RRC-EM for the ACGME; past chair of the ACLS subcommittee for the American Heart Association; and chair of the Ethics Committee for the American College of Emergency Physicians. He also served as Chief of Staff of University Medical Center in Tucson.

Sidney M. Stahl, Ph.D., is a medical sociologist with a specialty in gerontology. He serves as Chief of healthcare Organization and Social Institutions at the National Institute on Aging, National

Institutes of Health (NIH). He is responsible for research on healthcare delivery organization issues for older Americans as well as for research on elder abuse, end-of-life issues, long-term care, and caregiving. Dr. Stahl came to NIH in 1996 after having served as a researcher and professor of medical sociology and social gerontology at Purdue University and, more recently, as Deputy Director of the Department of Defense's National Quality Medical Program. He has published 4 books and more than 40 articles and chapters on the health of older Americans, social science factors in chronic disease, and statistical methods for the measurement of health in aging populations. He served as consultant to the World Health Organization in Geneva and Beijing as well as to several healthcare delivery organizations on the role of the social sciences in the delivery of services to older populations. He is active professionally in the Gerontological Society of America, the Association for Health Services Research, the American Public Health Association, and the American Sociological Association.

Randolph W. Thomas, M.A., received his undergraduate degree in Political Science from Chaminade University (Honolulu) and his master's degree in Political Science from the University of South Florida. He has been a Law Enforcement Instructor for the South Carolina Department of Public Safety, Criminal Justice Academy, for the past 11 years and currently serves as the Manager of the Domestic Investigations Unit. He has more than 22 years of law enforcement experience, primarily in the area of investigations, and has developed training material relating to the investigation of child and elder abuse and juvenile crime. He is responsible for instruction in the areas of juvenile delinquency, family violence, and investigations. Mr. Thomas is also the Project Director for the Academy's domestic violence training grant. He is a member of the South Carolina Adult Protection Coordinating Council and has served on a number of committees in the area of elder abuse. He has assisted in the review of domestic violence/elder abuse material for the American Bar Association. He also is an adjunct instructor at the University of South Carolina, College of Criminal Justice, and teaches courses in juvenile delinquency and child abuse. In addition, Mr. Thomas presents training to law enforcement and social service personnel in the area of elder abuse investigations throughout the United States.

D. Jean Veta, J.D., serves as Deputy Associate Attorney General at the U.S. Department of Justice. As Deputy Associate Attorney General, Ms. Veta advises the Associate Attorney General and the leadership of the Department on a wide range of legal and policy issues, with particular emphasis on oversight and management of e-commerce and technology policy matters, the Department's Elder Justice initiative, civil rights matters concerning education and lending practices, and issues affecting the Office of Justice Programs (which provides Federal leadership in developing the Nation's capacity to prevent and control crime, administer justice, and assist crime victims). Prior to joining the Department of Justice, Ms. Veta served as Deputy General Counsel at the U.S. Department of Education, where she supervised the divisions of Postsecondary Education and Legislative Counsel. Before joining the Government, Ms. Veta served as a partner in the Washington, D.C., law firm of Covington & Burling. She specialized in regulatory enforcement matters, served as the coordinator of the firm's Financial Services Practice Group, and represented clients in various civil rights areas. Ms. Veta clerked for United States District Court Judge Harold H. Greene from 1981 to 1982. She has been active in the American Bar Association (ABA) Section of Litigation for a number of years and currently serves as Secretary of the ABA Section of Litigation. She is a frequent speaker on litigation, enforcement issues, and regulatory matters. Ms. Veta graduated from Tulane Law School in 1981, where she was editor-in-chief of the *Tulane Law Review*. She also was awarded a Thomas J. Watson Fellowship in 1977 and graduated from Tulane University's Newcomb College in 1977.

Rosalie S. Wolf, Ph.D., received her B.S. degree from the University of Wisconsin and her Ph.D. in Social Welfare Policy with a concentration in aging from the Florence Heller Graduate School at Brandeis University, Waltham, Massachusetts. Currently, she is Executive Director of the Institute on Aging at UMass Memorial healthcare System, Worcester, Massachusetts, and Assistant Professor in the Departments of Medicine and Community Medicine and Family Practice at the University of Massachusetts Medical Center. Dr. Wolf is the organizer of the National Committee for the

Prevention of Elder Abuse (NCPEA) and currently serves as president. She also is editor of its international *Journal of Elder Abuse & Neglect*. In 1997, she organized, with colleagues from the United Kingdom and Argentina, the International Network for the Prevention of Elder Abuse, which she chairs. The Gerontological Society of America has bestowed on her its Donald P. Kent award for exemplifying the highest standards of professional leadership in gerontology through teaching, service, and interpretation of gerontology to the larger society. A major portion of Dr. Wolf's time in the past two decades has been devoted to the study of elder abuse in domestic settings. She has served as project director for three Administration on Aging-funded national programs dealing with information dissemination about elder abuse and coalition building and as a member of the management team for the National Center on Elder Abuse in Washington. Dr. Wolf has written numerous chapters and papers on elder mistreatment. With Karl A. Pillemer of Cornell University, she has coedited *Elder Abuse: Conflict in the Family* and co-authored *Helping Elderly Victims: The Reality of Elder Abuse*.

Wendy Wright, M.D., is a pediatrician at Children's Hospital in San Diego, California. She is an expert in the area of child abuse and neglect and regularly participates in the clinical assessment of potentially abused children and the education of healthcare workers, social services, and law enforcement regarding abuse issues. Recently, she participated in a California OCJP grant, lending her expertise in the area of forensic evaluations to the emerging arena of elder abuse. She has co-taught on the topic of elder abuse to healthcare practitioner audiences.

[Back to Top](#)

Observers

Beverly Alford

Assistant Director
Community Oriented Policing Services
U.S. Department of Justice

Alane Allman-Dent

Deputy Investigator
U.S. Senate Special Committee on Aging

Sara Aravanis

Director
National Center on Elder Abuse

Leslie Aronovitz

Associate Director
U.S. General Accounting Office

Timothy Baker

University of Pennsylvania
School of Nursing

Marie Boltz

Federal Monitor

Suzanne Bradley, R.N., Esq.

healthcare Financing Administration

Beverly Bryant

Treasurer
National Association of State Long Term
Care Ombudsman Programs

Lawrence Casper

Trial Attorney, Civil Division
U.S. Department of Justice

Tiffani Clark

Evaluator
U.S. General Accounting Office

Nancy Coleman

Director
ABA Commission on Legal Problems
of the Elderly

Mary Ellen Kullman Courtright, M.P.H.

Vice President & Program Officer
Archstone Foundation

Jeni Coyne

Ombudsman Specialist
National Ombudsman Resource Center
National Citizens' Coalition for
Nursing Home Reform

Carol Crecy

Director
Office of State & Community Programs
Administration on Aging

Daniel Dodgen, Ph.D.

Senior Legislative, Federal Affairs Officer
Public Policy Office
American Psychological Association

Joy Duke

APS Administrator
Virginia Department of Social Services

Toby Edelman

Staff Attorney
Center for Medicare Advocacy

Jamie J. Ferrell

President
International Association of Forensic Nurses

Janet Heald Forlini

Professional Staff
U.S. Senate Special Committee on Aging

Lauren L. Fuller

Chief Investigative Counsel
U.S. Senate Special Committee on Aging

William T. Gormley, M.D.

Assistant Chief Medical Examiner
Commonwealth of Virginia, OCME

Edith S. Gravely

Volunteer Guardian
Conservator Coordinator
Arlington County Dept. of Human Service

Suzanne Harang

Nurse Consultant
AFH

Malcolm Harkins

Partner
Proskaver Rose LLP

William Heffron

Senior Counsel
Department of Health & Human Services
Office of Counsel to the Inspector General

Sally Hurme

Program Consultant
AARP

Joanne Ivancic

Deputy Investigator
U.S. Senate Special Committee on Aging

Jerry Kasunic

D.C. Long Term Care Ombudsman Program
Legal Counsel for the Elderly-AARP

Nancy LaVigne

Special Assistant to the
Assistant Attorney General
Office of Justice Programs

Andy Lay

Assistant United States Attorney
U.S. Attorney's Office

Sarah L. Lock

Senior Staff Attorney
AARP Foundation Litigation

Daniel Lynch

Evaluator
U.S. General Accounting Office

Eileen Meier

Legislative Consultant
National Association of Orthopedic Nurses

Meg Morrow

Special Assistant
Office of Justice Programs
U.S. Department of Justice

Joan O'Sullivan

Assistant Professor
University of Maryland School of Law

Catherine Schuster Pascale

Assistant Attorney General
Medicaid Fraud Control Unit

Steven A. Pelovitz

Director, Survey and Certification Group
healthcare Financing Administration

James D. Polley IV
Division Government Affairs
National District Attorney's Association

Geraldine Redican-Biggott
Assistant Director
U.S. General Accounting Office

Mark E. Safarik
Supervisory Special Agent
Behavioral Analysis Unit-CIRG
FBI Academy

Traci J. Sanders
National Association of Attorneys General

Cynthia Sauchak
Investigative Specialist
Elder Abuse/Neglect
Las Vegas Metro Police Department

Dorothy Siemon
Senior Staff Attorney
AARP Foundation Litigation

Lori Stiegel
Associate Staff Director
ABA Commission on Legal Problems
of the Elderly

Patrice Harris Sullivan
Assistant United States Attorney
U.S. Department of Justice
U.S. Attorney's Office

Cecil Z. Swamidoss
Deputy Investigator
U.S. Senate Special Committee on Aging

Philip Thevenet
Professional Staff
U.S. Senate Special Committee on Aging

Andrea Tisi
Counsel
Office of Policy Development
U.S. Department of Justice

Melvin L. Tucker
Project Manager
Maine Community Policing Institute
The University of Maine

**Ilene Warner, R.N.C., M.A., M.C.S.P.,
N.H.A.**
Alden Geriatric Consultant, Inc.

Paul S. Weidenfeld
Assistant United States Attorney
U.S. Attorney's Office

Jim Wright
Director-Triad
National Sheriffs' Association

Marlene A. Young
Executive Director
National Organization for Victim Assistance

Barbara L. Zelner
Counsel
National Association of Medicaid Fraud
Control Units

Other Participants

Carol Cribbs
Chief, healthcare Fraud Unit
Justice Management Division

Carla Daniels
Technical Assistance Coordinator
Bureau of Justice Assistance

Pamela Frank
Project Coordinator

Erin McCormack
Project Coordinator
Community Research Associates

Jennifer McKinney
Assistant Project Director
Community Research Associates

Steve Miller
Miller Reporting

Rebecca Morris
President and CEO
Conference Reports and Internet Services
Division of Gallais Communications, Inc.

Tricia Y. Smith

Analyst, healthcare Fraud Unit
Justice Management Division

Sara White

Editor
Conference Reports and Internet Services
Division of Gallais Communications, Inc.

[Back to Top](#)

Short Papers

Ann W. Burgess, Elizabeth B. Dowdell, and Robert A. Prentky

Pilot Study of 20 Sexually Abused Nursing Home Residents Demographic Characteristics of Victims

Eighteen of the 20 sexually abused residents were Caucasian, widowed females older than age 80, a profile consistent with nursing home populations in general. Sixteen of the residents were white, 3 were Hispanic, and 1 was black. Fourteen residents were widowed, four were single and never married, and two were married. Ages of the residents were as follows: younger than 70: 16, 33, 55, and 63; in their 70s (n=5); in their 80s (n=9); and in their 90s (n=2).

All residents were in a long-term nursing home facility and required skilled nursing intervention. Although 5 residents were able to ambulate on their own, the other 15 were confined either to bed or to a wheelchair.

Mental Status

Although the majority of the residents suffered from a primary diagnosis of dementia or Alzheimer's disease (n=12), other cognitive and neurological disorders included cerebral vascular accident (n=3), brain trauma from gunshot wound (n=1) and motor vehicular accident (n=1), polynuclear palsy (n=1), amyotrophic lateral sclerosis (n=1), and major depression (n=1). Many had multiple physical disease diagnoses, such as stroke, cataracts, hypertension, diabetes, and congestive heart failure.

Method of Disclosure

Because of their dependent status and their cognitive limitations, residents did not have the ability to report abuse directly to law enforcement. Rather, the abuse had to come to someone else's attention or the resident had to bring it to someone's attention in order for the abuse to be noted. In the sample of 20, 4 major methods of disclosure were observed: (1) informing a family member (n=7); (2) informing a staff person (n=3); (3) abuse witnessed by staff or suspected by staff (n=7); and (4) clues detected by staff (n=4). Some cases included multiple methods of disclosure.

Perpetrator Identification

Although the majority of the residents had serious cognitive deficits, only three perpetrators went unidentified. Some residents were able to give a full description.

Physical and Forensic Evidence

The standard procedure in suspected sexual assault cases is to conduct a forensic rape examination. In the nursing home cases reported here, the examination often was difficult because of (1) the resistance of the resident to the pelvic exam (e.g., "legs drawn up and resists any movement of legs"); (2) not being able to visualize the pelvic area or complete the examination due to severe leg contractures (e.g., "legs contracted and would not open"); (3) difficulty in communicating and explaining the exam with demented and cognitively impaired residents (e.g., "Needed daughter present to communicate with mother"); and (4) difficulty obtaining reliable and accurate victim

report of the assault, injuries sustained, and regions of pain or discomfort (e.g., "When asked if she hurt anywhere or if anyone hurt her, she laughed and mumbled").

In 10 cases, no examinations were conducted, usually because of the delayed reporting, not believing the resident, or failing to follow protocol. Of the 10 exams that were conducted, 6 revealed some type of positive evidence ("intercourse, nontraumatic with copious amount of discharge"); 2 had vaginal bleeding but no sperm were noted; and 2 revealed no physical or forensic evidence. The primary evidence relating to a sexual assault included presence of semen and bruising in the pelvic area. Secondary evidence included vaginal or purulent discharge, evidence of a sexually transmitted disease, or positive findings of blood.

In four cases, there was redness and swelling noted in the vaginal area. The force of the assault, in 4 cases, left serious bruising. Forensic examination of an 89-year-old widow revealed separation of the symphysis pubis bone, an inguinal hematoma, and swelling and bruising to the right labia. It was difficult to examine the resident because she resisted any movement of her legs. Her groin was severely bruised, and she had a purulent vaginal discharge. She remained in fetal position, moaning in pain. She would not allow her blood pressure to be taken and would draw up her legs.

Rape exams were not completed on the two male residents. In one case, the doctor had heard rumors of abuse of this resident around the hospital but paid no attention because he did not think that the rumors were likely to be true. He had no training or experience in assessing sexual abuse of males. The second case was viewed as involving consenting sexual contact.

Discussion

In this study, 20 residents of nursing homes who had been sexually assaulted were examined. These residents predominantly were elderly victims who exhibited rape-related trauma symptoms, general symptoms of traumatic stress (e.g., fear, confusion, hypersomnia, lack of appetite, withdrawal), and an exacerbation of symptoms related to their primary diagnoses. These preliminary findings suggest that the presence of a preexisting cognitive deficit, such as a dementia, markedly delays information processing and impairs communication in a highly vulnerable population, which potentially compounds the trauma of the sexual assault. From both a clinical and theoretical perspective, there is every reason to believe that vulnerability due to physical frailty and emotional fragility places elderly victims at unusually high risk for severe traumatic reactions to assault. These victims simply are not equipped, either physically, constitutionally, or psychologically, to defend against and cope with the proximal effects of assault. Perhaps the single most profound result of the sexual assaults against these elderly victims is that 11 of the 20 victims died within 12 months of the assault. Because more than half of these victims were age 80 to 95 at the time of the assault, it cannot be asserted that the death was a distal effect of the assault. Although it is impossible to determine in each case whether the assault accelerated death, the fact that more than half of the victims died, not from the assault itself but within months of the assault, is clearly noteworthy.

Rape trauma syndrome, which includes both acute and long-term symptom responses to traumatic sexual assault, has two distinct variations: compounded rape trauma and silent rape trauma (Burgess and Holmstrom, 1974). In compounded rape trauma, victims have a past and/or current history of psychiatric, psychosocial problems that compound the effects of the sexual assault. In silent rape trauma, expression of assault-related symptomatology is muted, undetected, or absent. It was clear from this review of these 20 cases that the nursing home victims were subject to both compounded and silent rape trauma. Most of the victims had preexisting areas of weakness or vulnerability, primarily physical and cognitive, that served to complicate the assault symptom presentation. In addition, many of the victims suffered in silence, and the assault became known only after suspicious clues or evidence were noted by staff or family.

In a study of work-related rape, Brodsky (1976) reported that there is a difference in the initial reaction of the victim if the rape occurs when walking through a high-risk area where violence is expected or if the victim is attacked in what is considered "home territory." Brodsky defined home and work settings as safe ground and emphasized that adults have a stronger reaction when that safe ground is invaded.

In translating Brodsky's notion of territorial safety to the elderly, it easily may be argued that the nursing home is, for the resident, precisely that—a home, and that the staff function as the resident's caregivers (in both a literal and figurative sense). The nursing home and its staff are perceived as "safe," and violations represent a more profound betrayal of trust than violations committed outside the sanctity of the home.

Although this study represents a preliminary examination of what appears to be yet another area of "hidden" rape, the findings have obvious clinical, forensic, and policy implications. All nursing home personnel should be trained rigorously to identify signs and symptoms of assault-related trauma and to be vigilant to suspicious, preassault behaviors, including the same grooming and manipulation observed with most other sex offenders (Burgess, Prentky, and Dowdell, 2000; Prentky and Burgess, 2000). In particular, staff must be trained to detect the emergence of symptoms, including noteworthy changes in baseline behavior in victims who are likely to exhibit symptoms in a muted or "silent" fashion.

A thorough physical, cognitive, and psychosocial assessment must be completed at the time of admission to the nursing home. These assessments are particularly critical because they provide nursing staff and other caregivers with a baseline from which to judge behavioral changes. The American Nurses Association (1991) standards mandate that nurses take action when a patient's condition deteriorates. A major area of litigation results from failure to assess and respond properly to untoward changes in the condition of a patient.

Perhaps the most disturbing observation made was the frequently noted lack of sensitivity of nursing home staff to the gravity of the assaults on the residents. Responses ranged from cynical disbelief that anyone would sexually assault an elderly individual to what can be described as a perverse sense of amusement. There is a well-known pattern of bystander apathy and bystander inaction in response to crime (Shotland and Goodstein, 1984), and the same pattern appears evident in this case. However, one major difference is that these "bystanders" are not strangers who happen on a victim in the street. These bystanders are professionals charged with the care and protection of these residents.

Although this study has obvious limitations, most notably a small forensic sample that may not be generalizable to nonforensic samples, the findings are disturbing. As more is learned about this new subgroup of rape victims, four critical prevention areas require focus:
Screening procedures for hiring new staff.

- Training regimens for staff.
- New guidelines for conducting rape trauma examinations with elderly patients.
- Recommendations for increasing the safety of the nursing home environment.

References

American Nurses Association. *Standards of Clinical Practice*. Washington, DC: Author, 1991.

Brodsky, C. "Rape at Work," in *Sexual Assault: The Victim and the Rapist*, ed. M.J. Walker and S.L. Brodsky, Lexington, MA: Heath, 1991, 35-52.

Burgess, A.W. *Violence Through a Forensic Lens*. King of Prussia, PA: Nursing Spectrum, 2000.

Burgess, A.W., E.B. Dowdell, and R.A. Prentky. "Sexual Abuse of Nursing Home Residents." *Journal of Psychosocial Nursing* 38 (6) (2000): 10-18.

Burgess, A.W., and L.L. Holmstrom. "Rape Trauma Syndrome." *American Journal of Psychiatry* 131 (1974): 981-986.

Burgess, A.W., R.A. Prentky, and E.B. Dowdell. "Sexual Predators in Nursing Homes." *Journal of Psychosocial Nursing* 38 (8) (2000): 26-35.

Crowell, N.A., and A.W. Burgess. *Understanding Violence Against Women*. Washington, DC: National Academy Press, 1996.

Prentky, R.A., and A.W. Burgess. *Forensic Management of Sexual Offenders*. New York: Kluwer Academic/Plenum Publishers, 2000.

Shotland, R.S., and L.J. Goodstein. The Role of Bystanders in Crime Control. *Journal of Social Issues* 40 (1) (1984): 9-26.

Kerry P. Burnight, Ph.D.
University of California Irvine
College of Medicine
Assistant Clinical Professor

Elder Justice: Medical Forensic Issues Concerning Abuse and Neglect

What Areas of Further Research Would Promote the Detection and Diagnosis of Elder Abuse and Neglect and Forensic Application Thereof?

For hundreds of thousands of Americans, old age is unnecessarily, and at times, excruciatingly painful and humiliating as a result of elder abuse and neglect. As attendees of this roundtable, we have the opportunity to take a step forward in addressing a critical but underdeveloped area: the medical forensic issues concerning abuse. Our understanding, and therefore our ability to adequately address the problem, has been limited by the coupling of inconsistent definitions and systems; the complex, multifaceted nature of the problem; limited awareness/understanding on the part of the medical community; and the lack of support for systematic research. Areas of further research that would promote the detection and diagnosis of elder abuse and neglect and forensic application thereof include the following.

Detecting Elder Abuse and Neglect

The first step in helping the victims of abuse is finding them. From a medical perspective, there are seniors who have at least some contact with a healthcare provider and those who do not. Seniors in both groups are the victims of abuse and neglect, but research on the best identification strategy is dependent upon the group.

Seniors who have some contact with a healthcare provider. Despite the fact that the medical community sees tens of thousands of patients each day, healthcare providers account for a small percentage of the reports to adult protective services. Systematic research on the victim, perpetrator, and situational indicators (physical and psychological) of elder abuse and neglect could provide the basis of a sound, standardized medical *screening tool* for elder abuse and neglect.

Seniors who have no contact with a healthcare provider. Accurate screening by healthcare providers would not benefit those who do not receive health or social services. As millions of American seniors are enrolled in Medicare health maintenance organizations, one approach to understand abuse in "invisible" seniors is to use managed care data to identify seniors who have not seen a healthcare professional in a specified amount of time. A sample of identified seniors could be evaluated to look for abuse and neglect that would not otherwise come to the attention of mandated reporters.

Diagnosing Elder Abuse and Neglect

To determine whether injuries observed in examination are consistent with the history presented, we need to understand mechanisms of injury in the geriatric population. For example, while bruises are a common manifestation of physical abuse, they are also a normal physical finding in geriatric populations. Research on bruising (cause, duration, and color resolution studies) would help health providers in their assessment of accidental and inflicted bruises. There is also a need for medical forensic research on the circumstances surrounding the development of stage I, stage II, stage III, and stage IV pressure ulcers and the validity of the "spontaneous fracture" phenomenon. One way to understand the mechanisms of injury in older adults would be to establish a national database of witnessed, documented injuries in older adults. This database would be valuable in understanding how accidental and intentional injuries are likely to present in the geriatric population.

Documenting Elder Abuse and Neglect

To accurately document elder abuse and neglect, we need to systematically identify the elements of a well-documented and interpreted injury or condition. It would be interesting to determine to what extent physicians use cameras to document injuries and how greater use of photographic documentation may impact treatment and prosecution outcomes. This type of research would be instrumental in the development of a standardized elder abuse *documentation form* designed to improve the treatment and prosecution of cases of elder abuse.

Reporting Cases of Suspected Elder Abuse and Neglect

There is a need for research that examines the relationship between adult protective services (APS) and the medical community. It is critical to understand what type of medical expertise is most helpful to APS. Does the healthcare community have the expertise needed by APS? To what extent are experts in the healthcare community available to APS? How could we increase APS access to the expertise of the healthcare community?

It would be useful to determine whether there are systematic differences in the types of cases of elder abuse and neglect that are not currently being reported to APS. What role could the healthcare community play in finding and reporting such cases?

Testifying in Cases of Elder Abuse and Neglect

Research is needed to build our understanding of the role of medical forensic information in prosecution. For example, what medical documentation factors are associated with convictions for elder abuse and neglect? What factors facilitate or impede disclosure of medical information? Do referrals to a multidisciplinary medical elder abuse team impact victim outcomes or conviction rates? What types of medical expertise, evidence, or documentation would be most helpful to the law enforcement and legal community? Does the healthcare community currently have the expertise needed by law enforcement and the legal community? To what extent are medical experts available to the law enforcement and the legal community? How could access to needed medical input/expertise be increased?

Marie-Therese Connolly¹
Nursing Home Initiative Coordinator
U.S. Department of Justice

Elder Abuse and Neglect Prevention Efforts Through the Nursing Home Initiative

The Department of Justice Nursing Home Initiative was launched in late 1998 amidst reports of serious quality deficiencies in a significant percentage of the nation's nursing homes. In early 1999, a Department-sponsored focus group charged with recommending steps to reduce abuse, neglect, and fraud in nursing homes urged enhanced enforcement, training, and coordination across the board. Although the Nursing Home Initiative has focused on elder abuse and neglect in institutional settings, through it we also have attempted to undertake projects that will promote prevention of elder abuse and neglect in whatever setting it occurs. The Department's activities relating to medical forensic issues have included the following:

Stepped-up enforcement. Although there is no Federal elder abuse and neglect statute, the Department does pursue civil, criminal, and civil rights cases raising claims of elder abuse and neglect, primarily in institutional settings. These cases primarily are pursued under false statement and financial fraud theories. The Department, however, has sent Congress a new proposed Federal abuse and neglect bill to supplement and fill gaps in current Federal authority. This proposed statute would provide criminal, civil, and injunctive remedies where patterns of violations result in harm to residents.

Under the civil False Claims Act (FCA), an entity is liable for submitting false claims for payment of Federal funds. In recent years, the Department has begun to pursue FCA "failure of care" cases, where the Medicare program was fraudulently billed for services that were not rendered or were so grossly deficient so as to be tantamount to no care at all. The failure of care cases brought to date have involved serious injury or death of residents. The defendants were required not only to pay monetary damages but also to enter into agreements intended to protect residents—for example, by imposing a temporary monitor and requiring specific improvements in problem areas. The first failure of care cases involved individual facilities or smaller chains. We also are now involved in financial fraud and failure of care cases against some of the largest chains (with 300 to 450 facilities), several of which recently have filed for bankruptcy. In those cases, we are working closely with the Department of Health and Human Services, Office of Inspector General (HHS/OIG), and the healthcare Financing Administration (HCFA), to ensure implementation of agreements, between the corporation and OIG, that include temporary monitoring and systemic quality improvement measures to decrease resident abuse and neglect.

Similar cases also are being pursued against public facilities under the Civil Rights of Institutionalized Persons Act (CRIPA) for injunctive remedies. In addition, one Federal criminal case was brought against individuals who falsely stated that a resident's injuries—from which she died within 24 hours—were caused by a fall out of bed.

Medical forensic evidence in failure of care cases. Evidence of abuse and/or neglect is critical in failure of care cases. This evidence generally falls into two categories: resident level and systemic. Resident-level data include medical records of residents alleged to have been abused or neglected from any relevant healthcare provider and witness statements. Other potential sources of information are public safety and social service entities, and perhaps funeral homes, as well as the Minimum Data Set survey and payment records. In addition to resident-level evidence, facility or chain-level information may provide evidence of systemic abuse or neglect, such as:

- False statements about staffing levels, or about the qualifications or training of staff.
- Insufficient funds spent on food (leading to malnutrition), supplies (resulting in re-use of single-use supplies), or needed therapies (leading to diminished functioning).
- Minimum Data Set or Quality Indicators that raise red flags or indicate "sentinel events."
- Survey documents finding immediate resident jeopardy and/or consistently poor performance and/or multiple deficiencies in quality of care.
- Data maintained by ombudsmen, adult protective services (APS), advocates, frontline responders, and others, indicating historic problems at particular facilities or chains.

In the interest of effective prevention, intervention, and prosecution, it is critical that those who come in contact with potential victims of elder abuse and neglect-in any setting-are trained to detect, document, and, in accordance with applicable law, refer what they learn.

Multidisciplinary training. Between July 1999 and February 2000, the Department organized four multidisciplinary regional conferences on Nursing Home Abuse and Neglect Prevention. The broad spectrum of attendees included representatives of the Department; FBI; HHS/OIG; HCFA; State Attorneys General, Medicaid Fraud Control Units (MFCU); State survey, licensure, enforcement, Medicaid agencies; APS; State and local long-term care ombudsmen, medical examiners; VA/OIG; VA Community Health; police officers; firefighters; EMTs; physicians; nurses; social workers; and others with varied specialties.

Historically, cases raising issues of elder abuse and neglect have been handled by State and local law enforcement. The Department, however, has been stepping up its efforts in this area in partnership with HHS and our State and local colleagues. One goal of the conferences was to train Federal law enforcement on how to pursue civil and criminal cases with sensitivity to the public health considerations and the complex environment surrounding these cases.

A second goal was simply to bring together Federal, State, and local law enforcement, regulatory, social service, healthcare, and public safety entities with responsibility in the area to discuss these issues. Participants heard diverse views on investigating claims of elder abuse and neglect; what criminal, civil, administrative, and private remedies exist; examples of promising multidisciplinary efforts; and how to distinguish signs of abuse and neglect from benign causes.

Multidisciplinary coordination: State Working Groups. Another primary goal of the conferences was to form (or enhance) State Working Groups to pursue multidisciplinary efforts at the State and local levels. Often participants from the same State had never met before and were unaware of the other entities' functions or existence. Their discussions inevitably noted the chasm between those on the frontlines who respond to and care for victims of elder abuse and neglect and those responsible for enforcing laws prohibiting such conduct. Law enforcement cannot pursue a case unless it is notified of suspicions or allegations. But, even when the appropriate information is provided, these cases can be very difficult to pursue. In June 2000, representatives of the State Working Groups, various national organizations, and others met to discuss what they are doing and their successes and challenges, including the following:

- Groups are reaching out to police, ERs, firefighters, EMTs, MEs, surveyors, ombudsmen, APS, licensing, social service, and healthcare entities. One fire department is developing internal protocols for detecting and reporting suspected elder abuse.

- Some groups are meeting regularly to identify problems and solutions; some are creating referral committees to review each entity's worst cases, to analyze the data showing problem facilities, and to determine the most appropriate types of referrals or action.
- New cases have been opened based on referrals by group members and analysis of data.
- Prosecutors are reaching out to geriatricians, MEs, nurses, and other potential experts.
- One hospital is pursuing development of a forensic center that would provide expert medical opinions in cases of suspected elder abuse or neglect, similar to an existing program that evaluates cases of suspected child abuse and neglect.
- Some groups are learning to identify potential abuse and neglect in reading records.

Other States report significant challenges, including (1) coordination difficulties; (2) personality conflicts; (3) lack of clarity regarding who was responsible for what tasks and who, if anyone, was "in charge"; (4) limited scope and unevenness among group members' knowledge; (5) limited sharing of vital information due to unwillingness by some, or due to privacy and law enforcement prohibitions; (6) concern by some about law enforcement's involvement in elder abuse and neglect cases; (7) the size or demographics in some States; and (8) the lack of support or funding for such an effort from any source.

Despite these challenges, the State Working Groups have shown great enthusiasm and pent-up demand to develop better ways to address these issues. For example, one group expected a handful of people to attend the first meeting. Instead, they had 75 participants from about 25 different entities. The participants welcomed a forum to discuss their efforts, obtain better access to law enforcement, and develop a multidisciplinary response team. In fact, many of the State Working Groups' activities relate to improving the response to elder abuse and neglect, regardless of the setting.

While these efforts are a beginning, much remains to be done. Multidisciplinary efforts are as important at the national policymaking level as they are at the grassroots level. This discussion presents a valuable opportunity to identify recommendations and priorities on how to proceed.

Carmel Bitondo Dyer
 Baylor College of Medicine/Harris County Hospital District
 Associate Professor of Medicine/Director, Geriatrics Program

How Can We Identify the Physical and Psychological Markers of Abuse and Neglect?

How Should We Educate the healthcare Profession About These Forensic Issues?

The effort by the Department of Justice to examine the issue of abuse and neglect of older Americans is an admirable one. While some look only to the child abuse literature for clues to help deal with elder mistreatment, it is clear to gerontologists that not all the precepts apply to older adults. Children are assumed to lack capacity; adults are considered autonomous until proven otherwise. Children are on a trajectory of growth and development, whereas aging elders, who have made their contributions, become increasingly vulnerable.

A number of theories about the origins of elder mistreatment exist: overburdened caregivers, dependent elders, mentally disturbed caregivers, a childhood of abuse and neglect, or the marginalization of elders in society are all possible etiologies for this public health phenomenon. Despite the fine work done by protective service agencies and other social service organizations, the numbers of mistreated elders continue to rise. Perhaps there is an additional explanation, and perhaps physicians can help.

The Texas Elder Abuse and Mistreatment Institute is collaboration between the Texas Department of Protective and Regulatory Services-Adult Protective Services (APS) Division and the Baylor College of Medicine Geriatrics Program at the Harris County Hospital District. Together, we have directly cared for nearly 300 mistreated elders. Our data show that the majority of APS clients referred are suffering from depression and dementia. Clearly these two disorders can lead to elder self-neglect, but what about elder abuse or criminal neglect? Our analysis of the TDPRS-APS database shows that persons who suffer from self-neglect or medical neglect were more likely to be victims of physical, verbal, or sexual abuse. We believe that the depression and dementia seen in greater numbers of mistreated persons than in the general older population put elders at risk for becoming victims of mistreatment. One of the first steps in identifying the markers of mistreatment is for healthcare professionals to recognize that these risk factors include the classic geriatric syndromes, such as depression and dementia.

The best way to diagnose underlying geriatric syndromes is through the standard well-validated approach called geriatric assessment. Comprehensive assessments of cognitive, mental, and emotional health as well as functional ability and medical illness are evaluated routinely. Geriatric assessment is best performed by interdisciplinary teams traditionally consisting of nurses, social workers, and physicians. The TEAM Institute clinical interdisciplinary team includes the traditional members as well as APS specialists. The APS specialists are able to perform in-home investigations and obtain more information from collateral sources in addition to the comprehensive geriatric assessment performed by the medical team. Together we develop joint care plans of intervention and ongoing followup. We believe this approach results in better patient/client outcomes.

If risk factors for abuse and neglect, such as depression, dementia, and functional loss, can be treated and even reversed, the cycle of abuse or neglect can be broken. If these disorders are detected early rather than late, the use of comprehensive geriatric assessment of frail elders may even *prevent* elderly victimization.

Geriatricians are trained to perform geriatric assessment and to intervene and treat the disorders they detect. Since there are only 9,000 board-certified geriatricians in the country, it is critical for all physicians who treat adults to be able to recognize elder mistreatment and identify the risk factors. Medical, nursing, and social work students should learn as much about elder abuse as they do about child abuse and domestic violence in their respective training programs. Once elder abuse and neglect is detected, patients can be referred to geriatric teams for treatment.

At Baylor College of Medicine, every third-year student (the total number of students is 167 per year) accompanies APS specialists on one or two in-home investigations. An additional 130 trainees a year are exposed to our work at the TEAM Institute. Several others at Cornell University, University of California-Irvine, the University of Medicine and Dentistry of New Jersey, and the University of Minnesota are teaching physicians about medical-APS teams, but the principles of elder abuse and neglect need to be integrated into curricula across the country. Funding for educational programs is critically needed in every State.

Most of the research in elder mistreatment has been done by social scientists. My colleagues and I have contributed to the literature, but more medical research is needed to make the strong case to academic centers. We need data to prepare curricula that are evidenced based. There is a small but

dedicated cadre of researchers in the field; the support of the Department of Justice will be an important first step in raising the national awareness of the serious public health problem of elder mistreatment.

Carl Eisdorfer, Ph.D., M.D.
Professor and Chairman
Department of Psychiatry and Behavioral Sciences
School of Medicine, University of Miami

Donna Cohen, Ph.D.
Professor
Department of Aging and Mental Health
Florida Mental Health Institute
University of South Florida

Homicide-Suicide in Older Persons: Acts of Violence Against Women

Homicide-suicide (HS) incidents in the older population are intentional acts of violence, directed almost entirely against women. They are not suicide pacts or compassionate HSs where the perpetrator and victim(s) are old and sick. Recent research indicates that these HSs are violent events, usually always carried out by older men, against unwilling or unknowing spouses or older relatives. They are acts of depression and desperation, other forms of psychopathology, or domestic violence. The perpetrators have usually thought about or planned the dyadic deaths for months or longer, and there are clear warning signs that, if detected, could help prevent these tragedies.

Our descriptive epidemiological research in Florida has shown that rates in the population age 55 and older are twice as high as younger persons (Cohen, Llorente, and Eisdorfer, 1998). HSs also account for about 3 percent of all suicides and about 12 percent of all homicides in the older population. Applying these Florida figures to United States data, we estimate that about 200 HSs occur every year in persons age 55 and older, and most involve older men killing spouses or lovers. Therefore, at least 400 deaths are due to successful homicide-suicides each year (Malphurs, Eisdorfer, and Cohen, in press).

HS rates among the older population appear to be increasing in Florida as well as other parts of the country (Cohen, 2000; Eisdorfer and Cohen, 1999). Our Florida studies also suggest that one HS is botched (i.e., one person survives, usually the perpetrator) for every five that are successful. When HSs are unsuccessful, they leave the perpetrators to face criminal charges and prison sentences, but there is significant prosecutorial and judicial discretion (Cohen, 2000; Cohen and Wareham, 1999).

Therefore, clinical, social, forensic, and legal issues need to be addressed to improve our capabilities to intervene and prevent these tragedies. There are important roles for healthcare professionals, forensic examiners, law enforcement officers, and family members and professionals working in aging, mental health, and public health agencies to improve detection, intervention, and prevention (see the Violence and Injury Prevention Web site: www.fmhi.usf.edu/amh/homicide-suicide/index.html). Recommendations should be developed for the consideration of mitigating circumstances during criminal proceedings after unsuccessful HSs, and we need to develop more effective ways to detect and protect older women at risk for domestic violence.

Clinical Patterns

About 85 percent of HSs involve spouses or consorts, and the remaining victims are siblings or other

family members. There are at least three types of spousal/consortial HS: dependent-protective, aggressive, and symbiotic (Cohen, 2000; Cohen and Eisdorfer, 1999). A common feature of all three is a perception by the perpetrator of separation and an unacceptable threat to the integrity of the relationship.

One-third of older HSs are the aggressive subtype where there is a history of verbal and/or physical conflict and/or domestic violence. The male perpetrators are about 10 years older than the victims. Neither the perpetrator nor the victim has a physical illness. What usually triggers the HS is when the victim talks about separation or divorce, threatens to do so, or is making plans or actively moving out of the home. The action is usually a surprise attack, the homicide is usually violent, and the victim is shot or stabbed multiple times.

Half of spousal/consortial HSs are the dependent-protective subtype. The husband is usually 2 to 4 years older than his wife, he may or may not have a serious illness, but in most circumstances he is caring for a wife who is chronically ill. There is evidence of serious depression, including helplessness, hopelessness, and vital exhaustion, which in most circumstances has gone undetected and untreated despite frequent medical care contacts. Most of the men have seen a physician within a few weeks of committing the HS.

Twenty percent of older HSs are the symbiotic subtype. In these cases, the male perpetrator is usually a few years older than the victim, and both the husband and wife are usually sick. There is no suicide note signed by both parties, but neighbors and/or family members have reported that both individuals had talked about wanting to die or being better off dead.

One of our most distressing findings is evidence that the older women who are killed are not knowing or willing participants (Cohen and Eisdorfer, 1999). Most are shot in their sleep or in the back of the head or chest. It appears that HSs are unilateral decisions by men with controlling personalities with no evidence from surviving informants that the husband or wife had spoken about wanting to be dead or to be killed.

Intervention and Prevention

There are often many warning signs of the pending violence. Predisposing risk factors include advanced age and a long-lived marriage where one or both members of the couple have real or perceived multiple health problems as well as depression and other psychiatric problems in the perpetrator. Potentiating factors include a perpetrator with a controlling or dominant personality, the perpetrator as a caregiver, marital conflict, domestic violence, and family discord. Precipitating risk factors may include a real or perceived change in the perpetrator or victim's health, pending move to a nursing home, social isolation (staying home and rarely leaving the house), talk of divorce, pending separation, and increased use of alcohol.

These predisposing, potentiating, and precipitating risk factors have important implications. Although HSs have complex motivations, the common theme is an intense attachment of the older perpetrator to a relationship that, when threatened by separation or loss, leads to violent, lethal action. Clinicians should assess the risk for homicide-suicide in all older patients where the following exist: (1) a history of ideation about suicide or violence; or (2) older couples who have been married a long time and one or both have health problems or evidence of domestic strife or discord. Assessment can be complicated for many reasons, especially since the victim, rather than the perpetrator, may be the patient. The perpetrator may also resist evaluation.

The strong evidence of undetected and untreated depression in older perpetrators and the existence of domestic violence in about one-third of older HSs underscores the importance of careful interviews when one or both members of an older couple present for medical appointments. Since the de facto mental healthcare system for older people consists of primary care physicians,

substantial efforts are needed to increase their knowledge in recognizing and treating depression as well as ways to combat hopelessness in older people and their caregivers.

Interventions should include intensive treatment of depression and other psychiatric problems when appropriate, removal of guns or other lethal weapons, social support for spouses and families in caregiving situations, and appropriate interventions to deal with marital conflict-especially where the older woman is a potential victim of aggressive, lethal behavior. Intervention is complicated and should be done on a case-by-case basis. Separating the perpetrator and victim may be appropriate to diffuse the tension and protect the victim. A careful clinical plan is essential, however, since separation is often the trigger for violence.

Homicide-suicides are traumatic events that change the lives of family members in many ways and for a long time. Short- and long-term reactions are influenced by many factors, including the history of family relationships, the nature and level of family members' involvement with the perpetrator and the victim, personal coping styles, religious beliefs of family, culture, and influence of friends. Similarly, contact with law enforcement, medical examiners, and journalists in the investigative phases of the incident can affect outcomes. Supportive or counseling services should be made available to survivors.

References

Cohen, D. "An Update on Homicide-Suicide in Older Persons: 1995-2000." *Journal of Mental Health and Aging* 6 (3) (in press).

Cohen, D. "Homicide-Suicide in Older Persons." *Psychiatric Times* XVII (1) (2000): 49-52.

Cohen, D. "Homicide-Suicide in the Aged: A Growing Public Health Problem." *Journal of Mental Health and Aging* 1 (2) (1995): 83-84.

Cohen, D., and C. Eisdorfer. "Clinical Patterns of Spousal/Consortial Homicide in the Aged," paper presented to the 9th Congress of the International Psychogeriatric Association, Vancouver, British Columbia, Canada, August 24, 1999.

Cohen, D., M. Llorente, and C. Eisdorfer. "Homicide-Suicide in Older Persons." *American Journal of Psychiatry* 155 (3) (1998): 390-396.

Eisdorfer, C., and D. Cohen. "Homicide-Suicide Rates in Older People," paper presented to the 9th Congress of the International Psychogeriatric Association, Vancouver, British Columbia, Canada, August 24, 1999.

Malphurs, J, C. Eisdorfer, and D. Cohen. "A Comparison of Antecedents of Homicide-Suicide and Suicide in Older Married Men (in press)." *American Journal of Geriatric Psychiatry*.

Nock, M., and P. Marzuk. "Murder-Suicide: Phenomenology and Clinical Implications." In *The Harvard Medical School Guide to Suicide Assessment and Intervention*, ed. D.G. Jacobs. San Francisco: Jossey-Bass, 1999.

A paper prepared for the meeting "Elder Justice: Medical Forensic Issues Concerning Abuse and Neglect," Washington, DC, October 18, 2000.

William E. Hauda II, M.D.
Adult Services Medical Director
Inova FACT Center
Forensic Assessment and Consultation Teams

Development of a Forensic Center for the Collection of Forensic Evidence in Abuse and Neglect Cases

Beginning in 1997, a task force consisting of Virginia physicians with expertise in child abuse and Commonwealth's Attorneys experienced in the prosecution of child abuse cases met to develop a system to improve the forensic medical response to child abuse. Concerns of the medical community focused on timely, professional, and consistent quality of care for children in Virginia. Commonwealth's Attorneys' concerns focused on the same issues as well as the need for accurate, comprehensive medical information to assist in charging decisions and prosecuting child abuse cases.

The need for an organized forensic response to child abuse cases arose out of concern regarding how child abuse cases were currently handled. Injuries to a child when treated at a doctor's office or an emergency room may generate a report to child protective services or law enforcement for suspected abuse or neglect. During the investigative phase, further medical evidence may need to be collected to determine whether abuse occurred, what charges are appropriate, and what defenses may require challenges. This forensic information is above and beyond what the treating physician may be capable of documenting and does not directly relate to the medical treatment of the child.

In Virginia, several hospitals had developed programs and services for forensic medical examinations in child sexual abuse cases under the Sexual Assault Nurse Examiner (SANE) programs. Legislation had been enacted in Virginia in the late 1980s to allow payment for the collection of forensic evidence in cases of sexual assault (Virginia Code 19.2-165.1). The money came from a fund established by the Supreme Court of Virginia as a part of its victim services. The task force addressing the forensic response to child abuse recognized that the collection of forensic evidence in child physical abuse and neglect cases would involve medical procedures and documentation similar to the examinations for sexual assault. A legislative initiative was begun to change the law to allow payment to practitioners collecting evidence in cases of child physical abuse or neglect.

The task force set guidelines on the requirements of the examination, the examining practitioner, and the site where the exam would occur. Additionally, some effort was spent to outline the costs of collecting forensic evidence, including the practitioner's time, the cost of appropriate laboratory studies, radiographs, and written documentation. In July 1999, Statute 19.2-165.1 was altered to allow payment to physicians who were collecting evidence in cases involving the abuse of children younger than age 18. The statute required the Commonwealth's Attorney to provide the authorization for payment of the costs of evidence collection.

In July 2000, the Virginia General Assembly altered Statute 19.2-165.1 to include all criminal cases where medical evidence is necessary to establish that a crime has occurred. Exactly who can perform these assessments in adults who are the victims of physical assault or neglect has not been addressed formally. Currently, a Commonwealth's Attorney has the power to designate a physician or facility to perform this service.

In 1991, INOVA Fairfax Hospital became a site for one of the first SANE programs in Virginia. Currently, more than 500 examinations are performed every year by a group of highly trained SANE nurses. This year, INOVA Fairfax Hospital became a site for Pediatric Physical Abuse and Neglect assessments, and the hospital established the INOVA FACT Center. FACT stands for Forensic Assessment and Consultation Teams, as the center provides several services, including examinations

of suspected victims of adult sexual assault, pediatric sexual assault, and pediatric physical abuse and neglect. In addition, the center performs body cavity searches for evidence collection for the Fairfax County Adult Detention Center. FACT Center staff also routinely act as medical experts for the defense or prosecution in cases of sexual or physical assaults of both adults and children. The hope is that the center will expand into the area of elder abuse and neglect by developing protocols and appropriately trained staff to perform examinations and medicolegal record reviews.

Catherine Hawes, Ph.D.
Department of Health Policy and Management
School of Rural Public Health Texas A&M Health Science Center

Elder Justice - U.S. Department of Justice Roundtable Washington, DC: October 18, 2000

There is general agreement that elder abuse and neglect are serious issues, even though we know little about the nature and extent of the problem, the causes, the long-term consequences for the victim, or how to prevent or minimize abuse and neglect. What we can say with confidence is that current research, education, social and health services, and law enforcement systems fall woefully short of what is needed to protect elders from abuse and neglect. Indeed, these systems are, at present, manifestly inadequate to address the problem.

There appear to be a number of factors that are impediments to preventing elder abuse. These include problems of detection or recognition, problems of reporting, problems of proof or attribution, and problems with the usual way such problems are "resolved." Research and education are clearly essential in each of these areas, but so are some changes in the infrastructure we rely on to address elder abuse and neglect.

Recognition/Detection

There are clear problems with detection of abuse and neglect. One cause at least is apparent-there is no agreement about what constitutes abuse and neglect, even among professionals charged with preventing it. For example, one staff member in charge of an abuse registry at a State board of nursing felt that threats, yelling, and cursing by a nursing home employee to a nursing home resident did not constitute abuse. A staff member from a similar agency in another State felt that the actions resulting in "minor bruises" for a frail resident did not constitute physical abuse. Many CNAs in nursing homes also feel that handling residents roughly (e.g., shoving, shaking) or having "startle" reactions when residents exhibit physically aggressive or other challenging behaviors does not constitute abuse but, rather, "self-protection."

- **Needed.** An authoritative body should define abuse and neglect as it applies to the elderly.
- **Research needed.** To describe the nature and scope of the problem in community and institutional settings.²
- **Funding needed.** (1) For education of healthcare professionals and others about what constitutes abuse and neglect; (2) for a public awareness campaign about what constitutes abuse and neglect.
- **Education needed.** There should be additional education of staff in residential LTC facilities about the effects of dementia, meaning of behaviors, and effective means of addressing behaviors.

Understanding why health professionals do not recognize potential cases is more complex. For example, elders are often admitted to hospitals or seen by primary care physicians with evidence of deplorable hygiene, injuries (including bruises, lacerations, and fractures), skin breakdown, dehydration, and malnourishment. However, even when the problem is so grave that it prevents or delays planned medical procedures (such as surgery), or when a nursing home resident has unambiguous clinical indicators (such as abnormal lab values associated with long-term, severe malnutrition), healthcare professionals seldom suggest investigating the condition to determine whether abuse or neglect is involved. A variety of explanations are possible, including mistaken concepts of what is normal aging, a sense that there is nothing to be accomplished by reporting, a lack of knowledge of how to report suspicions, and so on. But the point is, we do not know why there appears to be inadequate recognition of potential abuse.

Another potential source of recognition and opportunity for prevention comes with interactions between community-dwelling elders and long-term care providers, including case managers, adult day care providers, and home health agency staff. This is particularly true in States that have a single access point for persons receiving Medicaid-funded services.

- **Research needed.** (1) To develop and test a set of indicators of likely abuse that could be used by healthcare professionals and others in a position to observe or interact with elders who have been subjected to abuse or neglect (e.g., morticians, EMTs). This would include research to test the indicators for sensitivity and specificity; (2) to identify characteristics of victims and perpetrators; (3) to develop and test assessment tools that could be used to identify elders who have been abused (e.g., history of injuries) or neglected, or are at high risk for abuse or neglect (e.g., dementia, behaviors, brittle support systems); (4) to identify any barriers to recognition of signs and to determine the conditions under which such indicators would be used.

- **Outreach needed.** To State agencies and community-based LTC providers to encourage them to screen for abuse and neglect.

- **Funding needed.** For the National Ombudsman Resource Center to expand their training of local ombudsmen (staff and volunteers) on detecting and reporting abuse and neglect in residential long-term care settings.

- **Education needed.** (1) Of healthcare professionals, particularly in emergency rooms, on normal aging and how to detect abuse and neglect; (2) of hospitals on appropriate treatment of older persons (since abuse in hospitals also occurs).

Reporting

Reporting of abuse and neglect is a disaster at nearly all levels. As with much family violence, abuse of elders by family members remains a secret. But even when the abuser is not a family member, there is a lack of reporting. Families and residents in residential long-term care settings are reluctant to complain and to report problems. Workers in these facilities are reluctant to report abuse and neglect when they observe it. And, as noted, healthcare professionals who are in a position to observe the consequences of abuse or neglect tend to underreport. Moreover, there may be a mix of reasons, including organizational imperatives, that militate against reporting by healthcare professionals.

Yet even if they do report to entities identified to address complaints of abuse or neglect, the response is sometimes inadequate. For example, some officials who receive allegations about abuse or neglect in nursing homes, such as ombudsmen and even State agencies (e.g., State survey agencies, boards of nursing), do not report the allegations to law enforcement or suggest the complainant do so, even when the incidents involve such law breaking as rape or assault. In addition, some officials charged with handling complaints have little training in forensics and investigative techniques. For example, some State agencies do not pursue allegations of abuse when

the incident is classified as "of unknown origin." Thus, for example, if there is no alleged perpetrator named, they may not pursue investigations of an incident in which there was clearly abuse (e.g., a nursing home resident with dementia has been beaten during the night shift). Further, State agencies feel trapped in a "he said/she said" situation, in which the allegation by a resident or family of someone in a residential LTC facility typically loses if there is no other witness. This was the kind of situation faced by victims of rape, but in nursing home cases, it often results in the case not even being investigated because the agency concludes it cannot "substantiate" the allegation. Finally, State agencies report that local law enforcement is disinterested in nursing home cases, ignorant of how to investigate cases, and disinclined to prosecute.

- **Research needed.** (1) That explores the reasons for reluctance to report allegations of abuse and neglect when evidence is observed; (2) to determine the extent to which there is knowledge of whether reporting is required and how such reporting should be done; (3) demonstrations of programs to improve reporting and evaluations of their effects; (4) that examines the effect of State laws on mandatory abuse reporting on how incidents are handled and whether law enforcement is appropriate involved.

- **Education/training needed.** (1) Of those who investigate allegations involving abuse of persons living in residential LTC settings (e.g., nursing homes, board and care homes); (2) for nurses, physicians, EMTs, social workers, and public health professionals on how to recognize and respond to potential cases of abuse and neglect.

- **Initiatives needed.** To increase coordination between those typically charged with investigating allegations (e.g., State survey agencies, ombudsmen, boards of nursing, adult protective services) and local police and prosecutors.

Attribution

Even if detection and reporting were improved, the problem of proof would remain. This is a profound problem in for elders in both community and residential LTC settings. There is a tendency, in effect, to blame the victims of elder abuse by regarding their "problems," such as pressure ulcers, fractures, wandering off and being injured, undernourishment, and so on, as inevitable consequences of aging and having chronic diseases. Indeed, this is the argument advanced by defense attorneys in civil cases. It is important to note that epidemiological/health services research can contribute to this.

Another complication in cases is the move toward respecting the autonomy of elders and their choices, some of which may involve accepting risks of negative outcomes as a corollary of maintaining the independence and quality of life the elder desires. Indeed, in assisted living, there is a move toward explicit "risk contracts" between the facility and a resident (although there are some concerns about the nature and fairness of some contracts). Thus, some negative outcomes or injuries may be a result of explicit choices by the elder or a caregiver that are intended to enhance the elder's quality of life. Distinguishing the effects of abuse and neglect from either the natural consequences of aging and of chronic disease or the consequences of genuine autonomy-enhancing choices is difficult.

A final issue related to attribution and elder abuse is specific to those elders living in residential LTC settings. There is a tendency in current State and Federal regulations and investigations to focus on an individual perpetrator, usually a CNA, while ignoring the facility practices that led inexorably to the abuse or neglect. However, prevention of abuse and neglect necessarily involves identifying those facility practices, taking steps to hold individual facilities accountable, and devising interventions to eliminate those practices.

- **Research needed.** That delineates between negative outcomes associated with disease processes that cannot be reversed or whose trajectory cannot be altered and those associated with inadequate care, including abuse and neglect.
- **Development and funding needed.** For forensic centers that can support clinical case findings and train multidisciplinary teams and coroners.
- **Education needed.** (1) In medical schools and residency programs for physicians in geriatrics, normal aging, and how to recognize abuse and neglect, as well as preventable decline from other sources; (2) for investigators on how to use both individual, resident-level data (e.g., medical records) and also facility-level data (e.g., cost reports, staffing data) to support attribution of neglect and abuse to deliberate facility policies.
- **Outreach needed.** To the healthcare community for expert witnesses.

Resolution

Issues related to resolution and prevention must also be addressed to achieve justice for elders. Little is known about existing efforts to prevent abuse and neglect, including the effectiveness of mandatory abuse reporting laws and nurse aide registries of persons banned from nursing home employment for abusing or neglecting residents. Similarly, there is no systematic and comprehensive compendium of existing community interventions to prevent abuse and neglect, even though there have been some initiatives funded by such Federal agencies as the Centers for Disease Control and Prevention and national and local foundations. For example, there is a DHHS Secretary's working group on elder abuse, but there is scant information available about their activities or conclusions. Moreover, there have been few, if any, rigorous, well-funded evaluations of the effectiveness of program interventions designed to prevent abuse and neglect.

Finally, we need to address the conundrum that may be faced by frail, dependent community-dwelling elders who have been victimized by a family caregiver. The result of any prosecution of the perpetrator may well have a negative outcome for the elder, who may be removed from the realm of the perpetrator but find himself or herself also losing the ability to live in the community. This is particularly true, given the paucity of long-term community-based services that would replace a family caregiver. Thus, the result may be removing the elder from the "clutches" of an abusive or neglectful family caregiver but placing the elder in an institutional setting in which he or she encounters a new set of losses and risks. (Of course, such a placement could be very positive in terms of both quality of care and life for the elder.)

- **Research needed.** To help determine what works and what does not. Demonstration projects and well-designed evaluations of prevention strategies for both community-dwelling elderly and those who live in residential LTC settings are needed.
- **Infrastructure needed.** A Department of Justice task force that will maintain and focus activities on elder justice in the area of preventing abuse and neglect.

Candace J. Heisler
San Francisco District Attorney's Office
Consultant and Trainer

The Criminal Justice System and healthcare Professionals: A Critical Collaboration to Protect Victims and Detect Abuse and Neglect

Investigation and prosecution of elder abuse and neglect are complex issues for the criminal justice system. Most peace officers and prosecutors lack knowledge about, understanding of, and training in the detection, investigation, and prosecution of cases. Most agencies do not consider abuse and neglect of the elderly an agency priority. Few have dedicated staff to handle these specialized cases. Referrals from other agencies and disciplines are anything but common.

Yet the reality is that as this country ages, the number of vulnerable seniors continues to increase. Thanks to medical advances, seniors are living longer than ever before. Many have amassed considerable private wealth. But these changes come at a price. Many seniors have outlived friends and spouses and are socially isolated. Changes in family structure mean that family members may be spread a considerable distance from aging parents with infrequent contact. Longevity is often accompanied by declining health marked by chronic medical and mental conditions requiring frequent visits to physicians, more medications, and longer hospitalizations. Injuries occur more easily, and medications to treat them often cause conditions that resemble injuries from abuse. Some diseases may lead to wasting. Others may result in ulcers, even with quality care. These conditions may be confused with neglect.

When criminal conduct has occurred, prompt detection, documentation, and referral are critical to permit the effective development of cases by the criminal justice system. For law enforcement, the following issues must be addressed:

1. Has a crime occurred? Are all of the necessary elements provable beyond a reasonable doubt?
2. Can the perpetrator be identified beyond a reasonable doubt?
3. Is the victim legally competent to provide evidence?

healthcare professionals play critical roles in resolving each of these issues.

In determining whether a crime occurred, healthcare professionals assist in case development by documenting injuries, preexisting conditions, and level of cognitive functioning. Toxicology screens pinpoint presence of drugs and levels. Medical evaluations document weight loss, wasting, apparent bruising, and skin breakdowns and their probable causes.

Critical tasks include patient screening, documentation, referral, and staff training.

Screening of elderly male and female patients for domestic and elder abuse and neglect in the emergency department and a variety of clinics, such as general medicine, orthopedics, and geriatrics, should be institutionalized, much like screening of women for domestic violence has become over the last several years. Screening questions need to be developed for elderly patients who are verbal. These should be administered (verbally or in writing), according to the abilities of the patient. Procedures to ensure examination away from possible abusers and disbelieving family members also should be developed.

Documentation must include written descriptions, use of body diagrams (maps), and photographing of all possible injury sites. When at-risk situations are disclosed or suspected, medical staff members need to offer community resources; make referrals, consistent with local law, to Adult Protective Services (or its functional equivalent); and provide safety planning services.

Medical facilities should evaluate which clinics are best able to meet the needs of elderly abuse and neglect patients and provide needed assessment, documentation, and expertise for the patient as well as criminal and civil justice systems. Development of geriatric assessment centers, such as in Harris County (Houston, Texas), may be beneficial. "One-stop shopping" may be in the best interest of the patient, the health facility, and the justice systems.

Medical facilities may also provide a unique and safe location for delivery of community services to patients. Medical facilities are one place an elderly abuse victim can go without arousing the suspicion of an abuser-caretaker. A hospital may be a safe place for elderly support groups to meet. Seniors often benefit from support groups that can improve patient health by reducing isolation, developing safety plans, and empowering through group therapy. Such a model has been developed in Wisconsin with considerable success.

Finally, medical professionals need updated training in the recognition, screening, and documentation of elder abuse and neglect. The training should address local reporting laws, how to work with criminal justice agencies, and State elder abuse and neglect laws. Training should be provided to every staff member whose duties include contact with the public. One such model training curriculum has been developed in California by the University of California and Children's Hospital in San Diego.

Because of severe underreporting of elder abuse and neglect, healthcare professionals are often the only professionals with contact with seniors. Thus, healthcare providers are uniquely situated to identify possible criminal victimization and stop their continuation. In most States, healthcare professionals are mandated to report suspected abuse and neglect. Yet the reality is that many are unaware of their reporting duties. Others may be aware but, for a variety of reasons, decide not to report. Sanctions for failing to report are largely nonexistent. Careful thought must be given to ways to encourage and support those who do report. Efforts to increase awareness of reporting laws and recognition of probable abuse and neglect situations must be expanded. If, after raising awareness, healthcare providers continue to disregard reporting laws, then sanctions for failure to report need to be employed.

Prompt reporting, consistent with local mandates, ensures that corroborating evidence from the victim, other witnesses, and physical evidence is collected before it can be destroyed, forgotten, or degraded.

If the elder has died, important questions of causation must be addressed. Medical examiners and coroners play a key role in detecting abuse and neglect. Their successful assessment requires (1) training of coroners, their deputies, paramedics, and mortuary personnel in recognizing suspicious elder deaths; (2) development of policies that encourage referral of all elder suspicious deaths to the coroner-medical examiner. Such policies need to encourage an "index of suspicion" when elderly persons die unexpectedly and suspiciously. Policies that discourage the autopsy of persons based solely on their age and the expense should be reviewed; (3) development of notification systems between medical examiner-coroner offices and law enforcement agencies to identify seniors who may be the subject of abuse, neglect, and/or financial exploitation investigations.

Because healthcare professionals often have ongoing and long-term contact with an elder, they are often aware of the key persons in that elder's life, such as caretakers and new friends and family. Since most perpetrators are the elder individual's family members and caregivers, identification of

these persons in the medical history often provides critical evidence. In addition, medical staff may observe interactions between the elder and family member that may raise suspicion or even constitute new criminal conduct.

Finally, in every criminal elder abuse and neglect case, a determination of the victim's legal competence to testify or engage in certain disputed conduct must be made. If the victim is competent, there may be no crime. If the elder is not, then other available evidence must be assessed to see if it is sufficient to prove a crime has occurred. In either instance, medical professionals provide critical information and evidence to the criminal justice system.

Before completing this paper, a brief word needs to be spent addressing how medical professionals can improve their community's response to elder abuse and neglect through collaboration with the criminal justice system and others:

1. Health professionals can participate in multidisciplinary elder abuse teams to identify cases of abuse and neglect, help craft effective interventions, and participate in multidisciplinary training.
2. They can participate in family violence coordinating councils and task forces to ensure that the needs of elderly abuse victims are addressed.
3. They can participate in Elder Death (Fatality) Review Committees. Such teams are well established for child abuse, are evolving in domestic violence, and should be developed for elder abuse.

David R. Hoffman
United States Attorney's Office
Assistant United States Attorney

The Role of Forensic Evidence in Successful Prosecution of Elder Abuse³

Elder abuse has been defined to include physical assault, emotional abuse, active and passive neglect, and financial exploitation. I will focus on the issue of neglect, especially in an institutional setting.

Too many frail older adults are victims of active neglect. The medical community (i.e., medical directors of long-term care facilities, emergency room personnel, EMS personnel, or any other first responder on the medical front) is an essential partner in identifying and reporting medical conditions that evidence neglect. Active neglect, including the failure to keep older adults nourished and hydrated by paid caregivers, is rarely prosecuted by law enforcement on any level-Federal, State, or local. The prime reasons are a lack of detecting, documenting, and reporting of appropriate cases; a lack of expert medical testimony to support such prosecutions; and a lack of training of law enforcement personnel to successfully prosecute such cases.

All too often, the defense of inevitability is offered by potential wrongdoers whose story in any other situation would be wholly discounted. For example, an older adult residing in a nursing home loses a significant amount of weight; develops multiple pressure ulcers at various stages, including stage 4; and dies of sepsis as a result of the pressure ulcers. The facility states that the older adult refused to eat, refused a feeding tube, and that nothing would have prevented the inevitable outcome because there were so many underlying medical conditions associated with the older adult. Her attending physician was also the medical director for the long-term care facility. Her nursing home records,

however, reveal that there was no documented refusal to eat, no refusal of a feeding tube, and very little regarding multiple conditions, except for possible cancer that had not, in fact, been diagnosed by any physician. No charges are ever brought because no case is ever identified for investigation.

Unfortunately, this scenario is not all that uncommon. While there are clear triggers for reporting of this case to law enforcement and grounds for investigation into the care that was rendered to the older adult, this type of case is often not reviewed by law enforcement. Recognition of forensic indicators, such as pressure ulcers and a lack of an underlying medical "wasting" condition, is critical to the identification of potential criminal or civil actions pertaining to the care rendered to some of the most frail and vulnerable members of our society.

Ian Hood, M.D., J.D.
Philadelphia Medical Examiner's Office
Deputy Medical Examiner

The Forensic Pathologist's Role in Investigation of Suspected Abuse or Neglect of Care-Dependent Persons

Intentional Physical Abuse

Physical abuse of elderly and other care-dependent persons is increasingly recognized in the nursing home setting and the injuries are the same as in any other case of battery, but the fragility of the victims has special implications for the interpretation of their injuries. Because of their fragility, such victims can die from mechanisms that would not seriously injure a more robust person. This may be offered as a defense. Rough handling by a relative nursing an elderly person might not be actionable, whereas the same action by a paid attendant (where a fiduciary relationship exists) would be. Gripping by the shoulders and shaking a young person may be unwise but legally permissible, but the same action directed toward a frail, elderly, incapacitated person can lead to death from head injury and can be criminally actionable.

Head injury. The frail elderly are particularly susceptible to the development of subdural hemorrhage between the brain and inner skull because of senile atrophy of the brain; this has led to the phenomenon of so-called "spontaneous" subdural hematoma in the medical literature, but most subdural hematomas are now considered to be due to minor and unremembered trauma. The frail elderly are also prone to falling as a result of transient ischemic attacks and osteoarthritis, and this has sometimes led to accusations of assault because of the proliferation of bruises and other injuries. However, the distribution and nature of injuries from falls does differ from that typically seen in a beating. Senile ecchymoses are very common in elderly persons and are also frequently mistaken for blunt trauma.

Delayed deaths. Delayed death is a common problem among the elderly, where quite minor trauma may set in motion a chain of events that leads to death in such compromised patients. The pathologist can assist in distinguishing between exacerbation of an underlying condition by an external physical event versus an independent intervening event, a distinction that is critical in deciding to press charges. The pathologist can establish the preexisting state of health of the victim and is critical in establishing that a battery caused death and not any underlying diseases, even though the underlying diseases may have been destined to cause death in the not-too-distant future. Accurate testimony is essential in successfully prosecuting cases where death was caused by either exacerbation of an underlying condition by trauma, or the death was contributed to by trauma but was also due, in part, to the underlying condition of the decedent.

Sexual abuse of incapacitated persons. Because such victims are often unable to complain of what was done to them, the incidence of this phenomenon is likely greater than statistics would suggest. Any vaginal or rectal bleeding found on postmortem examination of an elderly decedent must have its cause established.

Neglect

Decubiti and contractures. Often taken as the hallmark of neglect, the presence of these conditions is not probative of neglect; rather, their nature, distribution, and extent, and any evidence of management, must be taken into account in addition to the nature of the victim in whom they have occurred. In extremely compromised, frail, elderly individuals with combinations of such conditions as peripheral vascular disease, diabetes mellitus, stroke, and dementia, it may be virtually impossible to avoid decubitus formation on areas of the body that have bony prominences but must also support the body weight. Most notably, these include the hips and sacrum. Decubiti appearing elsewhere suggest inadequate management of a patient left for long periods with one leg crossed over the other or an arm crossed on the body without adequate padding, and there is little excuse for the development of decubiti over heels, prominences of the ankles, or knees. Ulcers that form on the labia of elderly women adjacent to indwelling urinary catheters are also suspect as indicative of improper management. Unlike intentional physical abuse, the underlying state of the victim does have an impact on the culpability of potential perpetrators when neglect is suspected as harming or killing a care-dependent person. Establishing a particular perpetrator is the major difficulty at present in attempting to bring criminal charges of manslaughter in such cases.

Contractures. The interpretation of these is also dependent on the condition of the victim who has them. They may be unavoidable in certain neurological conditions but are also usually predictable, and preventive measures can and should be undertaken. Allowing fixed contractures to develop, even in a predestined individual, without consultation and active management, is evidence of neglect and often leads to trading of accusations between professional medical staff, nurses, and physiotherapists. They are particularly likely to be the subject of fraudulent billing of intensive interventional physiotherapy for full range of movement of joints that subsequently turn out to have had no range of movement for months or years.

Malnutrition and dehydration. Examination at autopsy can establish the existence of these conditions, and, in the absence of any other more competent cause of death, they may indeed be the cause of death. Whether they arose from neglect or inadequate management requires careful review of records (adequacy of recordkeeping is a major issue in this area but is outside the role of a pathologist). Malnutrition is an important predisposing factor in many individuals whose deaths are due to other more immediate causes and may reflect improper management, but these conditions are also an acceptable method of managing terminal patients with family consent, particularly where the family has indicated unwillingness to have a nasogastric or PEG tube inserted.

Fractures. The occurrence of fractures in a frail, elderly individual is not proof of actionable neglect or abuse, but prolonged failure to detect them or mismanagement of them may be. They are often difficult to detect in nonambulatory, nonverbal patients, and some delay is understandable and acceptable. Investigation of the circumstances in which any particular fracture may have occurred is required to determine whether negligence or malfeasance was operative in causing them. At autopsy, a forensic pathologist can sometimes establish the mechanism by which a fracture was caused (a radiologist may do the same in a living patient) and can also assess the strength/fragility of both the bones that were broken and the general osteological strength of the patient. This may be important in establishing culpability. There is currently much debate about whether elderly frail, osteoporotic patients sustain fractures as a result of falling or suffer "spontaneous" fractures that then cause them to fall. An important concept to grasp is that of the pathological fracture. This term is applied to fractures in bones as a result of the existence of some underlying condition in the bone, most commonly a metastatic tumor, resulting in its fracture with minimal if any trauma. It is not

uncommon for elderly individuals, especially men with prostate cancer, to have underlying malignancies that have metastasized to bone, and these may lead to fractures from no more activity than rolling over in bed.

General Medical Management

A pathologist may be able to document some evidence that reflects improper management (for instance oral antibiotics given to treat a loculated fibrinous empyema), but this usually requires other expert opinion from clinicians in a position to comment on adequacy of medical management. Autopsy findings by a pathologist may also incidentally document a discrepancy between management received or, more commonly, not received, by a patient and that documented as given.

Ethical/legal issues. Pathologists often examine cases in which it is obvious that the patients' deaths were mismanaged rather than their illnesses. This is often the result of lack of proper prior directives on the part of the patient, uncertainty as to their roles on the part of the relatives and medical staff, and what the law requires of them in the circumstances. There is no consensus on what "comfort care" means, and medical staff and relatives are reluctant to undertake what they perceive as managed death of a patient even when it may be ethically, medically, and legally indicated.

Mark Lachs, M.D., M.P.H.
Weill Medical College-Cornell University
Co-Chief, Division of Geriatrics and Gerontology
Cornell University

Selected Clinical and Forensic Issues in Elder Abuse

A number of medical and social factors make the detection of elder abuse more difficult than other forms of family violence. The most problematic is the higher prevalence of chronic diseases in older adults. Signs and symptoms of mistreatment may be misattributed to chronic disease, leading to "false negatives" (e.g., fractures ascribed to osteoporosis instead of physical assault). Alternatively, sequelae of many chronic diseases may be misattributed to elder mistreatment, creating "false positives" (e.g. weight loss in a patient due to malignancy ascribed instead to intentional withholding of food).

Certain injuries in children of certain ages are "diagnostic"-little else can produce radiological findings such as these-and the findings must therefore be caused by child abuse. It is unknown if there are diagnostic injuries of elder abuse given the higher prevalence of chronic disease. Part of the research agenda in elder abuse should include studies to determine whether such injuries exist.

"Ageism" in society generally, and in medical practice specifically, is probably also a barrier to detection. Ageism in the medical encounter creates a therapeutic nihilism with respect to the capacity and potential of older people. For example, the death of a child from any cause (and especially from child abuse) is big news; children are not supposed to die. Unfortunately, the death of an older person is not especially noteworthy in our youth-oriented culture. The subtle complacency that these attitudes create may discourage an appropriately detailed evaluation when elder abuse may be the cause.

There are essentially no data on rates of underreporting in elder abuse, although some studies provide some indirect information. Among healthcare professionals, physicians tend to be rarest reporters of elder abuse to State agencies, and one survey of adult protective service professionals

suggested that doctors were the least likely group to uncover new cases, after social workers, nurses, paramedical personnel, and other health professionals. Another study indicated that elder abuse victims have substantial interaction with emergency departments, and that these may be missed opportunities for detection. Screening instruments to rapidly identify those at high risk is another area worthy of research efforts.

A recent well-publicized case of child abuse involved the exhumation of two young children who died in the early 1960s under mysterious circumstances. The findings of that exhumation were unmistakable injuries of child abuse; the death certificates listed SIDS and other diagnoses as the cause. This story is instructive in that the state of clinical science surrounding elder abuse in the year 2000 is about where child abuse was in the 1960s.

Erik J. Lindbloom, M.D., M.S.P.H.
University of Missouri
Assistant Professor of Family Medicine

How Can We Identify the Physical and Psychological Markers of Abuse and Neglect?

My interest in this area revolves around the identification of dangerous situations before severe abuse and/or neglect takes place. In my practice and in review of the literature, I have found it helpful to divide the "warning signs" into victim and perpetrator factors. Victim factors include obvious physical signs, such as unexplained bruises, burns, lacerations, or fractures. During a comprehensive visit with any of my older patients, I make an effort to perform a head-to-toe skin exam to detect any of these findings. If there is reluctance on the patient's part, I usually reassure them by explaining that I am looking for any abnormal skin findings, including signs of skin cancer. A potentially subtler marker for mistreatment is frailty. Easier to recognize than it is to concisely define, frailty is a state in which the body and mind have difficulty responding to stressors. Stressors could include disease, change of environment, personal care issues, or any form of mistreatment. A frail elder has been shown in numerous studies to be at higher risk of mistreatment, whether through increased dependence on the caregiver or through increased stress of the caregiver. I assess the patient's degree of frailty by reviewing recent past medical history (particularly looking for signs of chronic disease or incontinence), inquiring about independence in activities of daily living, and performing functional assessments such as gait and fall risk evaluations.

I believe the most significant psychological or neurological marker for the potential mistreatment victim is cognitive impairment. Strong evidence exists that cognitive impairment can lead to abuse and neglect, secondary to behavioral changes, inability to defend, or increased dependence. In addition, the delirious or demented victim is less likely to report instances of mistreatment, making cognitive impairment a huge risk factor for *unrecognized* abuse and neglect. In addition to screening for cognitive impairment in my older patients, I also screen for depression and substance abuse. Although there is more evidence supporting these issues as perpetrator risk factors, a few studies also report them as markers for the victim as well.

Perpetrator factors can be subtler and less specific, but I consider the caregiver evaluation as important as the patient evaluation during an initial office visit. In addition to screening for depression and substance abuse as mentioned above, I inquire about other mental illness, behavioral issues, or legal problems. Also important is the current relationship between the patient and caregiver. Is there a history of mistreatment (in either direction) in the past? Does the caregiver live with the patient full time? How stressed is the caregiver feeling? Is the caregiver financially dependent on the patient? These are all questions that may suggest an environment at higher risk for mistreatment.

What Areas of Further Research Would Promote the Detection and Diagnosis of Elder Abuse and Neglect and Forensic Application Thereof?

I think the key to future research is multidisciplinary collaboration. In the past, a medical research project may have been considered multidisciplinary if it included two different medical specialties. In more recent years, multidisciplinary teams in geriatric medicine have included physicians, nurses, nurse practitioners, social workers, psychologists, nutritionists, and home care providers. Meaningful research projects in the field of elder mistreatment should continue to cast a wider net of inclusion, using expertise from such fields as sociology, law enforcement, adult protective services, forensic science, and bioethics.

Consensus opinion is needed to help establish what constitutes elder abuse and neglect. There have been definitions published in the past, but gray areas still remain. In my own research, I have come across several instances that cannot be definitively identified as mistreatment. For example, if an older adult with dementia is an unrestrained passenger in a motor vehicle accident, is the caregiver and/or driver guilty of neglect? What if a mildly demented elder is allowed to drive back and forth to the store, even though a physician has expressed concern about that individual's driving ability? Is the caregiver responsible if an accident occurs? These are just some examples that may cause debate, but they probably would not be as unclear if the person in question was a child and not an older adult. The ambiguity and responsibility surrounding guardianship is an area of study that may help clarify some of these tougher situations.

I am also concerned, along with colleagues in my department, that research into elder mistreatment does not lead to an overly aggressive approach to elder death investigations. Given that the vast majority of deaths of those over age 65 are not the result of abuse or neglect, we must constantly sharpen our focus to include only those situations with substantiated risk factors or suspicious circumstances. Otherwise, we run the risk of overwhelming family members, friends, and other care providers who are already grieving a traumatic event. Continuing dialogue is needed among all fields listed above as we hope to advance public awareness and research of elder mistreatment. This elder justice roundtable is definitely a step in the right direction, and I look forward to participating.

Laura Mosqueda, M.D.
University of California, Irvine College of Medicine
Director of Geriatrics/Associate Professor of Family Medicine

"Medical Forensic Issues in Elder Abuse": Attempting to Define the Issues

Clinical forensic medicine relates to any area in which medicine, law enforcement, and the judiciary come into contact. It is a more well-developed science in other countries (notably the United Kingdom); the United States lags behind in knowledge, application, and acceptance of this field.

Elder abuse is a particularly difficult and complicated area within clinical forensic medicine. There are so many types of abuse, so many characteristics of the victim, so many characteristics of the perpetrator, so many socioeconomic contributors, so many cultural issues. How does one make sense of this entanglement?

The field of forensic medicine takes us beyond the objective physical findings that we, as medical clinicians, are used to seeing and documenting. A forensic approach challenges us to ask more questions:

- How did this happen?

- Why did this happen?
- Are these explanations plausible?
- Are these explanations acceptable?
- What other information (history, physical examination, laboratory studies, etc.) may support or refute the likelihood that this was the result of abuse?

(For purposes of this discussion, "abuse" will encompass physical, sexual, psychological, and financial abuse; abandonment; and neglect).

Markers of Abuse

One aspect of forensic medicine involves identifying markers/evidence of possible abuse. healthcare professionals are taught how to evaluate an injury from a routine medical perspective, but we are not taught how to analyze it from a forensic perspective. Does the mechanism of injury Satisfactorily correlate with the injury seen? Are there certain markers that *always* indicate abuse? Or do we look for a combination of the *type* of physical finding (bruise, pressure sore, fracture, etc.), the *location* of the finding (expected/unexpected), and the *explanation* (acceptable/nonacceptable) for the finding to make a conclusion about the likelihood of abuse?

When Is a Physical Finding Evidence of Abuse?

This is a particularly vexing question when the victim is an older adult. Sometimes it is obvious: cigarette burns on an arm, ligature marks on the wrists. But more often it is not obvious: the frail 82-year-old man on coumadin who comes in with multiple bruises; did he really fall, or did his short-tempered son push him down when he didn't move quickly enough? To complicate matters further, the victim often has a dementing illness that may render him incapable of giving a reliable history.

When the victim is quite frail, it may take minimal force to produce grave consequences. For example, a "small" shove from a caregiver may cause a fall that results in a subdural hematoma; this same shove may cause no harm whatsoever to a person who is robust. An elder with dementia may easily be pushed into delirium when benzodiazepines are improperly administered. So, the same action that produces significant injury to one person may cause little or no harm to another. We also know that many injuries occur despite excellent care, particularly in the most vulnerable elders. healthcare providers must learn what clues will distinguish an injury that is the result of abuse from an injury that was not reasonably avoidable.

Death Review

When an elder dies, there is a tendency to accept this as a natural act. What triggers ought to make us reconsider how "natural" the death was? Who is responsible for asking this question? Who is then responsible for deciding how vigorously to pursue the answer?

There may be some markers that we can agree ought to trigger an investigation: stage IV pressure sores, multiple bruises in unusual locations, unexplained dehydration, or malnutrition. An investigation must involve more than the coroner because a pressure sore caused by neglect looks no different from a pressure sore that arose despite all reasonable efforts to prevent its occurrence. Medical records will need to be reviewed with the hope that the primary care provider documented adequately the sequence of events leading to the sore. Information about the living situation will need to be gathered to understand who was responsible for the care of the elder and the circumstances under which he received care. But will the law enforcement/judiciary system think it is "good enough" if the medical team concludes the sore was unacceptable or unexplainable without being able to say it contributed to the elder's death? Will they still do an investigation and go forward with a prosecution?

When *can* we say that abuse contributed to death? Again, there may be obvious circumstances, such as a blow to the head that leads to a cerebral bleed and death in a matter of hours. But what about the kick to the abdomen that leads the person with Alzheimer's disease to stay in bed for days, resulting in deconditioning and an earlier-than-expected death? It would be hard for any one member of an interdisciplinary team to prove that the abuse caused an early death. I wonder: If there were better communication and coordination among the members of the team, would some of these cases go on to investigation and successful prosecution?

An Interdisciplinary Team Model

While I have read about many of these issues as they are described in the literature, my experience with an interdisciplinary team has taught me their real-world importance. Our medical response team consists of a geriatrician, psychologist, pharmacist, social worker, and gerontologist. The geriatrician attends two monthly meetings that are organized by county agencies. One is a multidisciplinary team, also attended by the district attorney, ombudsmen, adult protective services (APS), public guardians, police officers, and a psychologist. It is organized and run by APS and its purpose is to review high-risk physical abuse and neglect cases. The other is a fiduciary abuse specialist team, attended by the district attorney, ombudsmen, APS, public guardians, bankers, real estate attorneys, agents from Medicare and Medicaid offices, and a police officer from a fraud unit. Our medical team has been involved with 40 cases through these meetings. In addition, we provide consultation to our local APS, district attorney, and law enforcement personnel. This consultation may take the form of answering a question over the telephone, reviewing a case and offering advice through an e-mail system, and/or evaluating the alleged victim either in the home or office. We have found it beneficial to go to the home whenever possible for the evaluation; this is usually done by the physician and/or psychologist. The physical and emotional environment of the home are important components of our assessment. The team meets weekly to discuss all new cases from the prior week and to review the progress of ongoing cases. We are collecting data at various stages of the process and are developing tools for intake and assessment.

My intimate involvement with a multidisciplinary team "in the trenches" of elder abuse has convinced me of the urgency to get a better grasp of the issues described in this paper, to define the research questions implied, and to find a way to simplify the issues so that we answer some of the basic questions without oversimplifying them so that the answers are not valid.

Education

Education of healthcare professionals is a key component to improving our forensic abilities in elder abuse. At the University of California-Irvine, all family medicine residents are required to spend part of their rotation with APS workers. We have found this to be an excellent method to raise awareness of elder abuse and build an understanding of the role of social service agencies. We have also collaborated with Children's Hospital of San Diego and the University of California-Davis to create a day-long course on elder abuse. This course is designed for healthcare providers who are expert in geriatrics; i.e., it assumes a high level of geriatrics knowledge prior to the course. It then focuses on forensic aspects of elder abuse: How to recognize, document, report, and testify. It is taught by a geriatrician, pediatrician (expert on forensic medicine), adult protective service chief, and prosecutor.

These and other educational efforts are important first steps to building a cadre of experts who will be available to the seniors and agencies in their communities.

Conclusion

Intelligent, thoughtful, educated guesses as to models that are likely to work must be attempted and studied while we pursue the research and education efforts. Multidisciplinary teams, based in part on those used in child abuse and domestic violence, ought to be created for the purposes of evaluation and treatment as well as prevention. The teams must address the perpetrator as well as the victim.

All attempts must be made to bridge the cultural divide between healthcare providers, social workers/scientists, law enforcement, and the judiciary system. Until these teams are formally in place, we will continue to have a fragmented system that leaves some of our most vulnerable citizens without decent care.

The U.S. Department of Justice has an opportunity to advance this field of elder abuse by drawing attention to the topic, collaborating with other governmental and nongovernmental agencies, and putting its significant resources (financial and intellectual) into systems that will serve our elders and their families. I hope this forum is the beginning of a process that will move steadily forward.

Lisa Nerenberg M.S.W., M.P.H.
Consultant

Detecting and Diagnosing Elder Abuse and Neglect

Medical professionals' critical role in detecting and proving elder abuse has long been recognized. Medical professionals' expertise in distinguishing accidental or unavoidable injuries from those that are inflicted, evaluating the plausibility of defenses, and identifying health and medical conditions that signal abuse or risk, has been crucial in prosecuting offenders. It is very encouraging to see the significant progress that has been made in the development of medical forensics and how this information is being shared with protective service personnel. We are starting to see forensics experts consulting with adult protective services (APS) units and making presentations at protective service training events.

As important as medical markers are, however, they cannot be evaluated or interpreted alone. Other factors, including decisionmaking capacity and the psychological dynamics that often come into play, may be critical in determining whether or not crimes have been committed. I would like to expand the scope of the discussion to include some of these factors.

Evaluating criminal conduct often requires us to examine the victim's mental capacity. In some alleged sexual assault cases, for example, determining whether or not a crime was committed gets down to determining if the alleged victim possessed sufficient decisionmaking capacity to exercise informed consent. We know that there are no simple tests for decisionmaking capacity and that medical diagnoses alone are not enough. Our legal system requires us to evaluate capacity in functional terms, that is, on the basis of specific types of decisions. Much work remains to be done in determining how to assess capacity for specific decisions; we are farther along in some areas than others. For example, the recent interest in durable powers of attorney for healthcare has helped us achieve some agreement about healthcare decisionmaking, but there is less agreement about other decisions, including the decisionmaking capacity needed to consent to sexual relations, to give gifts, and to get married.

Psychological dynamics and processes also need to be explored. We have seen a great deal of interest in undue influence recently as professionals come to recognize that certain crimes cannot be evaluated as discrete incidents. Rather than taking a snapshot approach to investigating a particular criminal act, we sometimes have to roll back the cameras to understand what led up to it. Undue influence offers an explanation for how perpetrators can exercise calculated and deliberate programs of control and manipulation over their victims over time. Just as understanding domestic violence requires that we understand power, control, and patterns of escalating violence, similarly, in elder abuse, we often need to look at the control and manipulation that preceded the criminal act.

Physical abuse and neglect often have financial motives, which also need to be taken into account. Medical practitioners are likely to identify cases in which patients have been given dangerous doses of medications. How they evaluate a situation will vary depending on whether the person administering the medication was a well-intended but poorly trained caregiver, an adult child who stands to inherit, or the patient's wife of 2 months. All professionals who evaluate and investigate abuse need to understand the "bigger picture"-the context in which abuse occurs.

Training Needs of Law Enforcement Personnel

One of the primary challenges in training law enforcement about abuse is providing personnel with up-to-date information and skills as our knowledge base grows. Although many researchers have expressed disappointment in how little progress has been made in advancing the research on abuse, the same cannot be said for professional practice and law enforcement's response. When I wrote a curriculum for law enforcement 7 years ago, our understanding of the problem and how to investigate was nothing near what it is today. We did not know about the patterns of domestic violence against older women, or about "sweetheart scams," or suicide-homicides, or how to investigate and prosecute abuse and neglect in nursing homes, or about the myriad forms of financial abuse and how to prove them.

Law enforcement personnel need information about breakthroughs as soon as it becomes available. Police also need tools and training in how to make quick evaluations because they often do not have much time with alleged victims. Just as some police officers have started using simple screening tools, like the mini-mental status exam, to get a quick "read" on capacity, they also need training in how to identify gross indicators of neglect. A colleague recently told me about an egregious case of elder neglect that was discovered by an animal care and control worker in the course of investigating a complaint of animal abuse. A social worker who was also involved had failed to recognize the critical state the woman was in. Humane workers are very skilled at making quick assessments of gross neglect on the basis of nonverbal indicators, but few nonmedical service providers who work with the elderly, or police, have received any training in this area.

Problems with gaining access to information about specific cases has been another problem for law enforcement. Several participants have mentioned the importance of death reviews and coroners' investigations. I am pleased to say that we are making some progress in California. Last month, our governor signed a bill (AB 1836) that will require medical practitioners to submit medical records to coroners investigating abuse. Currently, coroners can request the information, but if it is refused, they have to go to court to get orders, leading to delays and added trauma to decedents' families. We are also starting to see the development of death review teams for elder abuse.

Training Needs of healthcare Professionals

Again, I would like to broaden the discussion to include the training needs of social service providers as well as healthcare professionals. The needs of both groups overlap, and much of the training that occurs in elder abuse is done in multidisciplinary settings. I also believe this multidisciplinary approach is appropriate owing to the interplay of medical, social, and legal factors in abuse cases.

All professionals who are likely to observe abuse need basic information about how the criminal justice system works. When I see talented trainers like Candace Heisler train health and social service providers in what prosecutors need to prove cases, you can see the lights go on. Once they understand concepts like the elements of a crime, how each element can be proven, standards of proof, and intent, they begin thinking in those terms. They further begin to recognize the critical importance of the information and knowledge they possess and start to see themselves as partners in the criminal justice process.

Health and social service providers also need training to help them understand how courts assess legal standards of capacity and decisionmaking. They need to understand that medical diagnoses are

not sufficient. They further need to work with attorneys and law enforcement in translating medical diagnoses into meaningful legal determinations.

Whenever possible, we need to capitalize on work that has already been done. Our colleagues in domestic violence have made tremendous strides in educating medical professionals, particularly emergency room personnel. We can build upon that work by adding segments on elder abuse to existing training programs. We also need to enlarge the range of health and medical professionals who receive training, to include geriatricians, cardiologists, rheumatologist, podiatrists, and others.

I would like to end by making a few comments on training needs in general. Adding elder abuse content to the curriculums of police academies and professional training and education programs is extremely important but it is not enough. Training needs to be ongoing and interactive. I am a strong proponent of multidisciplinary teams because professionals from different fields need opportunities to learn more about each other's expertise, the interface of their expertise, and how their knowledge and skills can be combined to increase our understanding and effectiveness. To advance forensics expertise in elder abuse, we need to use the same strategy we have used from the beginning-bringing together experts from different disciplines to discuss cases and determine how their knowledge and skills can be combined. As I mentioned earlier, we are starting to see forensics experts begin to work with social service providers, but more of this is needed. We also need to expand the range of expertise in these discussions and develop new areas of expertise. In addition to medical professionals and toxicologists, we need to include forensics entomologists, dentists, podiatrists, and many others. As more nursing homes are prosecuted for neglect, we need to develop expertise in evaluating the quality of care. To evaluate poor care, we need to understand good care.

I would like to see DOJ explore the use of computer technology to facilitate this type of ongoing interaction. Databases of experts could be developed to help prosecutors, police, and forensics experts "find" one another to share their expertise and experiences. Computer technology could also be used to identify expert witnesses across the country and provide easier access to relevant case law in elder abuse.

Joanne Marlatt Otto, M.S.W.
Colorado Department of Human Services
Adult Protective Services Administrator

Detecting and Diagnosing Elder Abuse and Neglect (Forensic Markers)

In many States, the markers or indicators of abuse and neglect that result in legal proceedings do not differentiate between whether or not the abuse occurred in a community or an institutional setting. However, there is often a very different interpretation and response to abuse and neglect, depending on where it occurred. Physical and sexual abuse and financial exploitation are more likely to result in legal intervention when they occur in the community. In some States, caregiver neglect has also recently been included in adult protective services statutes as well as in criminal codes. Since most States mandate the reporting of elder abuse, incidents of abuse that occur in the community often are reported to adult protective services (APS) and/or law enforcement. These reports may result in prosecution, although there are no national data to show how often prosecution occurs or is successful.

On the other hand, when any of these forms of mistreatment occur in an institution, it is unusual for criminal proceedings to occur. While theft, gross neglect, physical and sexual assault, and unexplained death may be reported to State regulatory agencies (often following an internal

investigation conducted by faculty staff), law enforcement is seldom called. If the event is reported to APS and/or law enforcement, the report usually occurs long after the incident occurred, resulting in the loss or destruction of essential evidence. Legal proceedings resulting from institutional mistreatment are more likely to result in civil litigation than criminal prosecution.

Determining when abuse and neglect are not the result of other conditions often requires medical expertise. Severe bruising may be the result of abuse-or may be caused by the aging process, disease, and/or medications. Sometimes, indepth medical evaluation and testing need to be conducted before abuse can be ruled out. The best way to determine when explanations of mistreatment are contrived to conceal abuse and neglect is to evaluate whether the explanation of the injury is consistent with any known physical or medical cause or condition. An example of this would be bilateral bruising in which the same patterns appear on both sides of the victim's body, indicating that the abuser grabbed or shook the victim with both hands.

According to the National Elder Abuse Incidence Study, only 8.4 percent of the reports to APS came from physicians, nurses, or clinics. This figure is surprisingly low, considering that most older people have frequent contact with physicians and are examined and tested regularly.

Applying the Forensic Science: the Integration of Medical Forensic Evidence With Law Enforcement

Prosecution would be enhanced if law enforcement made more frequent and timely requests to healthcare professionals, such as forensic nurses, for evaluation of physical evidence. Some healthcare professionals need training on testifying in court so that the information will be understandable and convincing.

The role of APS is often that of first responder. In that capacity, APS needs to quickly identify medical and criminal issues and report them to the appropriate entities. As the investigation unfolds, APS continues to have an important role in ensuring victim safety, arranging for appropriate services such as homemakers and meal delivery, providing emotional support to victims, and coordinating the efforts of all the professionals involved in the process. Local multidisciplinary teams are ideal vehicles for this coordination, since a variety of community agencies are represented and can be called upon to make recommendations and provide additional resources.

From child abuse programs we have learned that safety of the victim is paramount, that perpetrators frequently conceal or deny the abuse, and that victims of all ages and abilities are often able to provide valuable information if an investigation is handled with patience and skill. From the area of domestic violence, we have learned that often victims can take some responsibility for their own safety if they are given the information on how to do this.

An important first step in diagnosing and pursuing cases of abuse and neglect would be the participation of physicians, nurse practitioners, and/or forensic nurses on local multidisciplinary teams. While there are an increasing number of these teams in many communities across the country, it has been difficult to involve many healthcare professionals in the teams on an ongoing basis. Often the problem is that there are no funds to reimburse these professionals for their time. Making Department of Justice funds available through grants for this purpose would provide an incentive for their participation. In addition, teams of regional experts in medicine, law enforcement, coroners and forensic examiners, APS and the courts also could be trained to provide forensic case reviews and make recommendations on an ad hoc basis.

Educating the healthcare Profession on Forensic Issues Surrounding Elder Abuse and Neglect

While elder abuse reporting laws vary from state to state, the indicators of abuse and neglect are remarkably consistent:

- All healthcare professionals should be trained on the civil and criminal laws relating to elder abuse and neglect, as well as indicators, reporting requirements, and services available.
- Medical residents and nursing students could be assigned to work with adult protective services as part of their residency or field placement experience, and participate on community multidisciplinary teams.
- Community bioethics committees could invite healthcare professionals to do presentations and become active members.
- Scholarship incentives could be provided to encourage students to specialize in geriatric medicine.
- Schools of Social Work could invite healthcare professionals to teach courses and work on collaborative research projects.
- National organizations, such as the American Medical Association, National Sheriffs Association, National Organization of Chiefs of Police, and National Association of Adult Protective Services Administrators, could be invited to participate in policy forums and encouraged to develop more cross-training conferences.

Improving the Forensic Science of Elder Abuse and Neglect: The Research Agenda

- Little is known about the actual incidence of deaths resulting from elder abuse and neglect.
- Research is needed on how often healthcare professionals encounter elder abuse and neglect, why they do or do not report, and what their experience has been if they do report.
- Another much needed area of research is the financial cost of elder abuse to emergency services, hospitals, Medicare, Medicaid, and insurance carriers.
- A study of the number of cases of elder abuse and neglect that have been successfully prosecuted would be very helpful.
- More training at the graduate level as well as increased public awareness could do much to overcome the invisible nature of this issue. Since victims themselves do not self-report or advocate for services, it is the responsibility of professionals in healthcare, law, social work, aging and other disciplines to do so on their behalf.

Gregory J. Paveza, M.S.W., Ph.D.
 USF-School of Social Work
 Associate Professor

Educating the Health Professions

When considering the issue of educating the healthcare profession, I believe it is important to remember that we are talking about several different professions, not just physicians, including physician assistants, nurses, social workers, psychologists, and dentists. Depending on the setting, these are often the firstline contacts for older adults. Beyond this group are occupational therapists, physical therapists, recreation therapists, respiratory therapists, home health aides, and many more who come in contact with older adults. It is important to recognize that each of these healthcare

professions has a different controlling authority that dictates the nature of the curriculum to be taught to its students.

From an educational standpoint, it is important to recognize that these accrediting bodies tend to view educational needs from the broadest perspective (that is, their view tends to be the basics a person must know to practice at the entry level). The accrediting organization provides guidelines for that level of education. The specific nature of those guidelines varies widely from the professions that specify elements of the curriculum (medicine and social work, for example) to professions that are relatively loose as to what must be specifically taught (psychology, for example). Regardless of the types of guidelines, however, the accrediting body does, on some regular basis (every 5 to 7 years), reexamine the curricula and ensure that a particular school is meeting the guidelines. Curricula tend to reflect the current sense of best practices or well-established beliefs about what should be the core elements. Thus, movement in curricula tends to be slow and often behind what may be the perceived need for a profession to have specialized training in a field.

Dependency on waiting for accrediting bodies is likely to result in little immediate change and certainly does not address the broader need for professional education on forensic issues. This then suggests that an alternative must be found for training.

Continuing medical education (CME) or continuing education (CE) for the other healthcare professions offers an alternative. However, choices of programs in CME or CE abound. Practitioners tend to gravitate toward programs that reflect the individual practitioners' own interests. Unfortunately, elder abuse and elder mistreatment in general tend not to be among the topics most likely to draw persons to programming. Moreover, when persons do choose to take training in elder abuse, participants often are seeking information about the current laws and the current system. This was brought home to me from personal experience. For 3 years as part of a summer training program offered by a major national aging organization, I offered CE training in elder abuse. The focus of this training was on identification of elder mistreatment, gathering and preservation of evidence, and serving as an expert witness. There was also some additional focus on the history of the field and the development and transition of elder abuse legislation. However, this course did not attempt to address specific State statutes, since the population that this national organization targeted was often from several adjacent States. The course description was detailed in what would be presented but excluded a clear statement that particular State statutes would be covered. Interestingly, the response to this workshop was often weak with only a few people signing up. When more persons did sign up, the major criticism of the course was that it did not cover the State statute of the host city in sufficient detail.

This complaint tends to reinforce the defined belief that most persons seeking CE or CME in the area of elder abuse and neglect are doing so to understand their local statutes and the systems that support these laws. So then, what can be done? A few States recently have passed legislation mandating that to have one's license renewed a person must have a specified number of hours of training in a particular family violence subject. These laws, which are largely in child abuse and domestic violence, demand that training be received. Unfortunately the amount of training usually required is minimal, in some cases as little as an hour every 2 years. The classes, therefore, tend to be rudimentary, and many focus on the statutes rather than on any particular training needs.

What needs to be taught?

First, health professionals must be taught to identify those who are abused, then they must learn how to gather initial evidence and how to preserve and protect that evidence so that it can be used. Finally, they must be taught how to provide testimony in a fashion that is convincing on direct examination and stands up to cross examination. However, until we identify the means to deliver the information, we will remain at a standstill.

Future Research Directions in Elder Mistreatment

In 1997, I suggested (Paveza, 1997) that the field needs to begin to be more specific in the direction of its research. I noted that the work of many of the early studies, while critical for bringing the problem to the attention of the research and general communities, lacked the specificity needed to be of much value to persons practicing in the field. I suggested that it was time for research to address the fact that elder abuse is not a single phenomenon but, rather, is several distinct entities and that definitions and profiles of those both at risk for abuse and those at risk for becoming perpetrators must become type specific. We need to know who is most likely to be physically abused and who is most likely to be neglected. We also need to know whether or what the relationship is between these two forms of mistreatment.

But while these descriptive epidemiologic studies are important, more critically we need to see support for research that provides the information about what distinguishes those who are abused or neglected from those who are not. We need risk factor studies that allow us to begin to say with some certainty what puts people at risk for abuse and neglect. These same factors can then be tested to determine their utility in helping healthcare professionals working with older adults to identify those who are being abused and neglected. We need a range of studies that build on each other, and some that are even repetitions of each other but with different samples. The tendency to avoid funding similar studies or studies that are repetitions of previous work needs to be put on the table. I often wonder how our understanding of lung cancer and its relationship to smoking ever would have advanced if we had been so locked into a nonsimilarity/nonrepetitive mode.

Funding needs to come from a variety of sources, all of which have vital interests in a better and more detailed understanding of the critical forensic issues. Included in these funding sources are both the National Institute on Aging and the National Institute of Justice. Without support for critical studies defining both the critical forensic indicators and studies that also look at the development of working forensic teams in this area, we run the risk of making policy recommendations that later are challenged or more critically debunked. This will only lead once again to a response that suggests there is no feasible way to address these types of social-legal issues.

Paveza, G.J. (ed.) "Mistreatment of Older Adults." *Journal of Mental Health and Aging* New York: Springer Publishing Company, 1997.

Karl Pillemer, Ph.D.
Department of Human Development
Professor, Cornell University

Critical Research Needs in the Study of Elder Abuse

The past two decades have seen dramatic advances in our knowledge about several types of interpersonal abuse. A number of major population surveys on wife abuse, physical child abuse, and child sexual abuse have helped establish reliable prevalence estimates of these problems. Scientifically conducted case-control studies have more definitively specified risk factors for such maltreatment.

That similar progress has not occurred in the field of elder abuse is widely acknowledged. With some notable exceptions, our knowledge about maltreatment of the aged has not significantly advanced since interest began more than 15 years ago. Although speculative discussions of elder abuse abound, rigorous research evidence is still relatively scarce.

The lack of scientifically credible research is not just an academic concern. The paucity of firm findings regarding elder mistreatment makes it difficult to develop practical solutions to the problem, including methods of identifying persons at risk of maltreatment, preventing abuse, and treating victims when abuse or neglect occurs. In this short overview, I will touch on several problems in the research base and make recommendations for how research should address these problems.

Key Problems in Elder Abuse Research

Several weaknesses in elder abuse research limit the usefulness of findings, including the following:

Data sources. Research on elder abuse has been inconsistent due to the sources of data on the problem. Most studies are small, nonrandom, unrepresentative, and largely exploratory in nature. The majority of studies have relied on surveys of professionals and/or reviews of agency records. There are obvious methodological problems with samples of cases that have come to the attention of a social agency or reporting authority. It is widely recognized that these are highly selective samples and that there is a large reservoir of unreported and undetected cases of elder abuse about which very little is known. Unreported cases may be quite different from cases that are reported, and risk factor profiles must take this difference into account.

In contrast, very few studies have been based on actual interviews with victims (or perpetrators). Only a few random sample surveys have been conducted in this country that address elder abuse (although several surveys have been conducted in other countries, including Canada and England). No nationally representative survey of elder abuse has been conducted (in contrast to child abuse and wife abuse). Case-control studies, a mainstay of research on other forms of family violence, have been employed only a handful of times in elder abuse research. Put simply, despite years of interest, there are still only a small number of empirical studies that meet contemporary social scientific standards.

Definitions and measurement. Research results on this topic are difficult to analyze because of poor definition of the term "elder abuse." Some researchers refer to a vast range of problems the elderly can experience as "abuse," including lack of proper housing, untreated medical conditions, and lack of social services. Most studies to date are weakened by their undifferentiated treatment of various types of abuse and neglect. That is, all forms of maltreatment are lumped together, despite evidence that the forms of abuse and neglect differ substantially. Further, definitions have differed so widely from study to study that the results of research are almost impossible to compare.

Related to the definitional issue is that of measurement. Many investigators have not developed their own research instruments but, rather, have simply analyzed forms used by service agencies. These forms are not designed for research and rarely provide data of the type and quality to be of use to researchers. With few exceptions, studies have not developed reliable and valid instruments to detect abuse.

Study populations. Widely varying criteria have been used to determine study populations. Some researchers have included persons younger than age 60 in their samples, and others have limited their research to persons 60 and over. Other investigators have limited their studies in various ways (for example, to persons sharing a residence or to elders dependent on a caregiver). This inconsistency again makes research findings difficult to compare and synthesize.

Lack of evaluation research. There has been almost no effort to seriously evaluate intervention programs for elder abuse. Experimental demonstration projects are very rare and have not involved randomized, control group designs. We know very little about the relative effectiveness of various programs to prevent and treat elder abuse.

Due to these (and other) shortcomings, we do not have sufficient data available to answer two of the most important questions about elder abuse, which have both scientific and policy implications. First, is the problem of substantial magnitude to warrant significant public attention and large-scale attempts at intervention? Better data on the true prevalence of elder mistreatment are needed in deciding what actions government ought to take on this issue.

Second, what are risk markers for abuse and neglect? What characteristics of elderly persons make them vulnerable to abuse? To plan and implement intervention programs, policymakers and service providers must learn more about the demographic, social, family, and ethnic characteristics of elderly persons that place them at risk of abuse. A vigorous research agenda is critical if we are to answer these questions.

Research Priorities

Major research needs in this area include the following:

General population surveys should be conducted. Incidence and prevalence studies of the general population are greatly needed to estimate the extent of elder abuse and to identify risk markers. Longitudinal studies are particularly critical to examine cases in which maltreatment develops over time.

Issues of definition and measurement should be resolved. Researchers must reach consensus on operational definitions of maltreatment. Funding for consensus conferences on this topic would be very useful.

Attention to elder abuse in nursing homes (and other institutional settings) is needed. Thus far, the discussion of elder abuse has been heavily focused on abuse that occurs in family situations. Research on the causes and dynamics of abuse and neglect in institutions is greatly needed.

Studies should focus on the consequences of abuse. Research should address questions such as the following: What effect does being an elder abuse victim have on the individual? What are the physical and psychological sequelae of elder abuse? Recent longitudinal research has, for example, indicated elder abuse as a mortality risk factor. Additional studies of this kind are greatly needed.

Studies that compare different cultural groups are necessary. Patterns of elder mistreatment may differ greatly in different racial, ethnic, and cultural groups.

Rigorous evaluation research is needed. Elder abuse programs, which have proliferated around the country, should be evaluated. For example, what are the effects for victims and their families of protective services programs? To what extent does mandatory reporting assist in the identification of elder abuse victims? Further, demonstration projects are needed in which different treatment modalities or prevention strategies are scientifically evaluated.

Susan M. Renz, M.S.N., R.N., C.S.
RS Connection Inc.
Medical/Legal Geriatric Consultant

Elder Justice: Medical/Forensic Issues Concerning Institutional Abuse and Neglect

The physical signs of abuse are dramatic and incomprehensible. They include burns, welts, bruises, imprint injuries, fractures, and rectal/vaginal bleeding. In the absence of pathology and/or injury that is nonmalicious, the aforementioned indicators strongly suggest abuse as their cause. Repeated admissions to the emergency room with the older adult presenting with these clinical findings should raise the suspicion of the healthcare provider.

Less dramatic, but equally serious, are the indicators of psychological/emotional abuse, which include new onset depression, mental status changes, social withdrawal, unexplained weight loss, and avoidance of contact with family and friends. These behaviors/conditions often are the result of psychological trauma due to verbal berating, forced social isolation, intimidation, harassment, and humiliation by caregivers.

Active/passive neglect is becoming more identifiable given recent media attention relating to inadequacies of care in institutional settings. By definition, passive neglect means the deprivation of goods and services that are necessary to maintain physical and mental health, without a conscious attempt to inflict physical or emotional distress. Conversely, active neglect implies intent to harm, or the willful deprivation of services. Signs that either passive or active neglect have occurred include poor physical hygiene, unexplained weight loss, decreased mobility, decubitus ulcers, and inattention to signs of illness.

The question remains: Why do abuse and neglect occur in institutional settings? There are some clear reasons why the elderly are vulnerable. One reason is the lack of knowledge of the institutional caregivers of the normal aging process and the expected sequelae of chronic disease progression. There are distinguishable characteristics between the normal and expected negative outcomes of the aging process and those conditions that result from failure to provide clinically timely and competent interventions. Second, our current healthcare system (especially nursing homes) places a high premium on task efficiency as opposed to individualized care. As a result, frail older people present with complex medical and psychological issues that are often undetected, oversimplified, or ignored. Standardized care plans, the norm in many facilities, are rarely gerontologically sound, nor do they promote the choice and the autonomy of the person to be served. The impetus to homogenize care results from the perceived need to maintain the time schedules and routines of the facility. The result is staff failure to assess and respond to resident needs due to time constraints (passive neglect), the choice not to provide care due to conflicting demands (active neglect), and *expressed* frustration of staff directed at the resident (abuse.)

The institutional caregivers' fundamental lack of knowledge relating to the needs of the frail elderly coupled with an attitude that dismisses individualized care, results in (1) a lowered expectation of care, and (2) a negative impact on the quality of life of the institutionalized residents.

Research is needed to examine the impact of the following in preventing elder mistreatment:

- Mandatory gerontologic core curriculum for all levels of institutional healthcare staff. The content would include normal aging, attitudes toward aging/ageism, common acute/chronic illness, restorative/rehabilitative care, and abuse/neglect prevention.
- A standardized requirement for clinically competent leadership presence at the care delivery level, i.e., replace current model of "supervision" with ongoing education and support.

- Changing the prevailing healthcare delivery system to promote individualized resident needs.

The creation of an interdisciplinary task force is necessary to refine and focus this research agenda. This task force requires legal, medical, direct care, and administrative representation to address systemic causes and solutions.

Arthur B. Sanders, M.D.
Division of Emergency Medicine
University of Arizona Health Sciences Center

Elder Justice Roundtable: An Emergency Medicine Perspective

Elder mistreatment is a complex social problem that is often hidden and ignored. Elder mistreatment includes physical abuse, physical neglect, psychological abuse, psychological neglect, and financial exploitation. Acts of mistreatment may be intentional or unintentional. Elder mistreatment is best approached as a complex syndrome with a multidisciplinary integrated approach to helping older patients live free of mistreatment. In some patients, the legal system will be a key element in protecting the person and preventing mistreatment; in other cases, the social service system will be key; in still other cases, the medical care system will be important in helping the patient. Most cases, however, will be unique and will need input and problem solving from a variety of disciplines.

While elder mistreatment has some aspects in common with other forms of domestic violence, there are also fundamental differences that do not allow us to impose the model we use for child abuse or spousal abuse to elder abuse. Key differences include issues of cognitive impairment and decisionmaking capacity, functional ability, co-morbid conditions, financial dependency, and the lack of pathognomonic signs and symptoms. The social support systems in communities are often lacking in resources and funding compared to child abuse programs.

Emergency healthcare professionals, including physicians, nurses and paramedics, can play a role in the detection and reporting of elder mistreatment. The role, however, must be clearly defined and part of a larger system of investigation, assessment, and treatment for possible mistreatment. One study in the emergency medicine literature showed that paramedics, trained in detecting signs and symptoms of elder mistreatment in the home environment, could have a positive impact when accompanied by a good system of geriatric assessment and the provision of social services. This will usually involve a well-coordinated local or regional system of investigation, assessment, and care once a report of a possible problem is rendered. Key questions for consideration of the emergency medicine part include the following:

Do Mandatory Reporting Laws Make a Difference in Outcome?

It is unclear from the literature that mandatory reporting makes a significant impact by itself. The debate over mandatory reporting often takes us away from other more important elements, such as adequacy of resources for followup and social services.

Which Patients Should Have a Forensic Physical Exam Done in the Emergency Department Setting? What Are the Key Elements of the Exam? Who Should Perform the Exam?

The emergency healthcare system will provide medical care for the consequences of mistreatment, such as lacerations, contusions, fractures, and hydration. If a legal exam is needed for forensic purposes, this should be standardized and should activate the geriatric assessment system. The literature on legal exams for sexual assault victims indicates that a standardized exam by a few well-trained examiners is best. Many communities have sexual assault response teams staffed by well-trained nurses receiving medical direction from nurses who perform the legal exam and obtain

evidence given to the police. The response team nurses coordinate followup care with community resources, give social support, and testify in court.

Should All Older Emergency Department Patients Undergo Screening for Elder Mistreatment? How Should Screening Occur?

Screening every older patient for elder mistreatment is unproven and needs to be formally evaluated before any statement can be made. We do not know the most effective screening/case finding tool. The outcome of suggested tools applied in the emergency department setting is unknown.

What Should the Role of Emergency healthcare Providers Be?

Emergency healthcare providers need to be educated about high-risk signs and symptoms of elder mistreatment. When patients present with the appropriate risk factors, in addition to the standard medical treatment, emergency healthcare providers will:

- Report a possible problem to the coordinating agency, such as adult protective services (APS) or Area Agency on Aging. Someone from the responsible oversight agency will be available 24 hours a day, 7 days a week, to discuss the situation.
- If there is concern about immediate danger, the APS professional will see the patient in the emergency department and arrange for a safe placement. If all parties agree that there is no immediate danger, the APS professional will arrange for a home visit within 7 hours and geriatric assessment as needed to address the problems.
- If a forensic exam is needed, the APS professional calls the police and the local forensic exam procedure is followed using the standard exam form and format.

How Should Emergency healthcare Professionals Be Educated?

The most effective educational programs would be local clinical guidelines and pathways that are consistent with national standards. Interdisciplinary bodies have the resources to institute these programs. Local leaders in medicine, geriatrics, and emergency medicine, hospitals, and social service and law enforcement agencies would be included in the planning and oversight. There would be an initial rollout of the program followed by yearly educational sessions and feedback to appropriate disciplines.

Sidney M. Stahl, Ph.D.
Chief, healthcare and Social Institutions
National Institute on Aging
National Institutes of Health

The Need for a National Investment in Research on Elder Abuse and Neglect

The National Institute on Aging/National Institutes of Health (NIA) is sponsoring a National Academy of Sciences (NAS) panel to examine current knowledge and help in establishing a national research agenda on elder abuse and neglect. The need for this broad perspective is evident considering the paucity of research in this area (Chalk and King, 1998). It is NIA's position that rigorous scientific research on this topic is needed to inform the social service, legal, and medical communities about elder abuse and neglect-related issues, such as prevalence, risk factors, diagnostic specificity, consistent measurement, the social consequences of family disruption, and institutional abuse and neglect. While society, medicine, and government agencies at all levels recognize elder abuse and neglect as a significant social problem, there is little scientific information about its causes,

prevalence, or consequences to guide the socially mandated work of prevention, detection, or treatment.

While NIA is active in research on aspects of elder abuse and neglect, it is clear that the scope of this endeavor requires a multiagency activity. The Department of Justice, the Administration on Aging, the Communicable Disease Center, the American Bar Association, the American Medical Association, and multiple disciplinary partners are required to successfully document and ultimately change the prevalence, detection, prevention, and treatment of elder abuse and neglect in the United States.

Recent NIA-supported research has received national attention and highlights the devastating consequences of abuse and neglect. In what is arguably the most important research in this area in the last decade, Lachs et al. (1998) undertook a 13-year prospective study of abuse and neglect using a cohort of 2,812 individuals. They report that only 9 percent of the population with reported abuse and 17 percent of those with reported self-neglect survived to the end of the study period. By contrast, fully 40 percent of those with no reported abuse or neglect survived the 13 years of cohort followup. Not a single death was attributable directly to abuse and/or neglect. The all-cause mortality odds ratio (OR) for those abused to those with no adult protective service (APS) report is 3.1; the OR for those self-neglected is 1.7. Since the research controls for known mortality risk factors (e.g., chronic disease, socioeconomic status, social factors, cognitive status, and demographic facts), it is clear that preventing abuse and neglect can have a significant impact on mortality and perhaps disability as well.

Unlike child abuse, a potential ethical dilemma in elder abuse and neglect involves abuse and neglect that may be part of an ongoing family dynamic. Since families create unique patterns of interaction to cope with and survive everyday living and adversity (Becker, 1997), any disruption in that interaction pattern, even though ethically appropriate, may produce unintended consequences. Research, as well as the more practical need to intervene in an unsafe environment, must remain cognizant of this potential.

Despite the availability of service programs, legal requirements for reporting abuse and neglect, and a growing recognition of the problem, the ratios of reported to suspected and reported to undetected elder abuse and neglect are low. Using reported data from the National Center on Elder Abuse (1998), an estimate of "reported" to "suspected but unreported" abuse and neglect is approximately 19 percent. (The study design used to acquire these data is problematic and represents a significant *underestimate*.) The ratio of "reported" to all abuse and neglect is unknown; however, the U.S. House of Representatives Committee on Aging (1990) reports that one in eight cases of elder abuse are reported. The Committee contrasts this figure with the one in three cases of child abuse reported. Not surprisingly, the overall prevalence of elder abuse and neglect in the United States is, as noted above, unknown.

Given this set of issues, there is a need to create a consistent and rigorous research agenda of sufficient scope so as to begin to provide practitioners with science-based information. Suggested problem areas are listed briefly below. The NAS panel will examine the feasibility, elaborate on, further specify, and prioritize these areas.

Unknown Prevalence and Inadequately Specified Risk Factors

Problem. There is no probability-based estimate of the prevalence of elder abuse and neglect in the United States. Estimates, based on small area analysis or convenience samples, range from 1 to 15 percent of the older population having experienced some form of abuse or neglect. The most typically cited figure is derived from NIA-sponsored research (Pillemer and Finkelhor, 1988). The 3.2 per 100 population estimate (lifetime prevalence, since age 65) is derived from an area probability survey of the Boston metropolitan area. The only similar study was undertaken in Amsterdam and

indicates a 1-year prevalence of 5.6 percent (Comijs et al., 1998). Because we lack probability-based prevalence estimates, our knowledge of risk factors is also subject to the potential biases inherent in availability or limited samples used in various studies. Therefore, social service interventions are planned for an unknown prevalence event and address at-risk populations using inadequate knowledge of risk factors most strongly associated with abuse and neglect.

Solution. To determine the magnitude of the problem and to identify risk factors of abuse and neglect, it is essential to determine the feasibility of initiating a national probability-based survey of the prevalence of elder abuse. To accomplish this task and to address the second problem of inadequate measurement, a three-stage solution is proposed:

- NAS will convene a panel to address central problems of the definition and measurement of elder abuse and neglect. The NAS panel is likely to be composed of experts on elder abuse and neglect, on the measurement of stigmatized social behaviors, on the measurement of social behaviors and social facts that are notoriously difficult to measure (e.g., recreational drug use, sexual behavior), and from various service agencies that are potential stakeholders in the outcome of research addressing elder abuse.
- A series of area-based and population-targeted pilot investigations will be considered to test the validity and reliability of operationalizations recommended by the NAS panel.
- If NAS recommends the approach, NIA will seek partners to fund and conduct an area probability survey of elder abuse and neglect. The outcome will be an estimate of the prevalence of and risk factors associated with these phenomena.

Inadequate Measurement

Problem. There is no accepted definition of what constitutes elder abuse and neglect. Virtually every published report begins by creating its own unique, albeit similar, criteria. Given multiple objectives, some of this variability is inevitable. The consequence is, however, variable risk factor and prevalence estimates. Measurement intended to identify abuse or neglect as a medical problem may examine different objective criteria than will adult protective service definitions intended to coordinate outcomes with local law enforcement agencies. The American Medical Association's *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect* (1992) emphasizes documentation of primarily physical signs and symptoms of abuse (for example, "[A] detailed description of injuries. . . . an opinion on whether the injuries were adequately explained"). While it is impossible to provide a single metric for all purposes, it is possible to provide reasonable, consistent, and generally agreed-upon definitions for integrating research, detection, and service needs.

Solution. The NAS panel is charged with examining this problem.

Prevalence Changes and Natural History of Abuse and Neglect

Problem. One of the key problems in this area is a lack of information about cause and effect. Is elder abuse a learned reaction to stressors that therefore tends to occur within families? We do not know if abuse is a determinant of frailty or if frailty is itself a precursor for caregiver abuse. There is reason to believe that elders, especially those suffering from dementing disorders, are likely also to be perpetrators of abuse on their typically older caregivers (Phillips et al., 1995).

Solution. NIA will consider sponsoring research on the natural history of abuse in the older population. Based upon NAS panel recommendations, this may be undertaken as an ongoing followup to the initial prevalence survey, or it may be a separate initiative.

Lack of Diagnostic Specificity

Problem. Physicians are often the only individuals outside the family seeing an elderly individual on

a somewhat regular basis. Because of that relationship and his or her training, the physician is in a unique position to be able to recognize signs and symptoms of elder abuse and neglect. Yet, despite legal requirements, only a very small fraction of abuse and neglect is reported to adult protective services. Among the barriers is the lack of unique signs and symptoms (Breckman and Adelman, 1988) and the confusion between signs of aging, symptoms of disease, and abuse and neglect. Since the differential diagnosis of many common geriatric presentations includes elder abuse and neglect, it is critical to develop diagnostic techniques enabling providers to distinguish between abuse and neglect and chronic disease (Lachs and Fulmer, 1993). Fractures may result from osteoporosis or physical force; depression, typical in elderly patients, may be an appropriate response to an abusive environment; inappropriate serum drug levels may reflect noncompliance, overmedication, or undermedication. Social service workers and law enforcement officers are equally unprepared to recognize abuse and neglect. This lack of knowledge, coupled with ageism (assuming that a frail, dependent elder is unable to determine what is in his or her best interests) led in part to the AMA's development of its Elder Abuse and Neglect Guidelines (1992) and a number of NIA-supported research projects. Detection is difficult for a number of reasons. Abuse and neglect are multifaceted phenomena, including a protean assortment of interpersonal behaviors (Rathbone-McCuan, 1980).

Solution. There is a pressing need to conduct research to develop and empirically demonstrate sensitive and specific signs and symptoms of elder abuse that are applicable to a variety of screening situations, including medical practice, social welfare settings, and community police efforts. The AMA Guidelines are not evidence based and are seriously deficient in specificity. While NIA currently supports nascent research in this area, it is necessary to empirically demonstrate sensitivity and specificity across a variety of settings. Based on NAS recommendations, NIA will consider developing an initiative with other interested agencies to create detection tools useful in a variety of settings. This translation research will build on knowledge gained in the risk factor portion of the survey and the standardized definition portion of the NAS panel.

Lack of Scientifically Verified Prevention Interventions

Problem. The *Journal of Elder Abuse and Neglect* has been publishing for a decade as the only publication devoted to this topic. It is thin on rigorous scientific content. This circumstance is not unusual in social problems areas where immediate and practical solutions are needed. What remains unusual is that there has been little progress in the development of science for testing the efficacy of preventive interventions. The NAS/Institute of Medicine's multivolume study of *Violence in Families* (Chalk and King, 1998) found only two studies in the thousands reviewed that met their criteria for scientific rigor (Scogin et al., 1989; Filinson, 1993). Given the availability of behavioral intervention strategies, practitioners' use of group therapy, and social science's growing knowledge of family dynamics and the caregiving role, the lack of formal tests of intervention strategies is remarkable. Sutor and Pillemer (1990) suggest that the caregiver role can be productive of a form of "negative" social support or resentment, which may lead to abusive or neglectful behaviors. Contemporary research in caregiving and social psychology indicates that social support confers morbidity and mortality protection through biomedical processes (Seeman et al., 1994) as well as through cognitive processes (Berkman and Vaccarino, 1993). Using frameworks developed in the social and behavioral sciences provides a powerful theoretical basis for developing hypotheses and testing interventions about the role of social, organizational, and process variables that impact prevalence and recidivism in elder abuse and neglect.

Solution. To provide the social service community with tools for the prevention of elder abuse and neglect, and to develop further knowledge about the role of family and caregiving associated with this social problem, a two-stage approach is suggested:

- A meta-analysis of the myriad of papers addressing elder abuse and neglect interventions to determine underlying consistency in the studies reported to date is needed.

· Research is then needed on scientifically verifiable interventions to prevent elder abuse and neglect and to eliminate potential recidivism. Do most vulnerable individuals "invite" abuse and neglect? If so, what interventions are appropriate to intervene between abuser and victim? Does elder abuse and neglect cause a collapse of personal resources to maintain self-integrity, or is the increasing frailty of certain individuals itself sufficient to produce consequent abuse and neglect?

Use of Nursing Homes for Self-Neglect Intervention

Problem. Lachs's research (1998) suggests that nursing home placement may be an intervention for self-neglect. Nursing home placement is, by its very nature, a radical, restrictive, and expensive alternative to other forms of community, in-home-based interventions. The field of aging increasingly emphasizes self-care and community-based resources for older Americans. Given Lachs's findings, it is unclear whether it is possible to integrate sufficient and/or appropriate service provision to keep self-neglecting elders out of more restrictive environments.

Solution. Research is needed to determine social triggers and risk factors resulting in nursing home placement for self-neglected older individuals. Intervention research focusing on the self-neglecting elder and his or her community integration is needed. Are there effective mechanisms currently available in the community that can address basic IADL needs to avoid nursing home placement? Does social policy dictated by Medicare militate against self-care or assisted self-care outside the restrictive nursing home environment? What results have SHMOs or the PACE program had that increase independence of older Americans and thereby decrease the risk of unnecessary morbidity, nursing home placement, and premature mortality?

Institutional Abuse and Neglect

Problem. We know precious little about the prevalence, forms, perpetrators, or victims of abuse and neglect in institutional settings. Despite persistent allegations that abuse of nursing home residents is widespread, this topic has been granted only limited, and from a cursory examination of the literature, decreasing research attention (Pillemer and Hudson, 1993; Everitt et al., 1991). Research evidence of neglect and abuse is limited and seems confined to specific behaviors such as nutrition (Kayser-Jones et al., 1998) and the use of physical restraints (Evans et al., 1997). Very little research has been done on physical abuse, institutional neglect (e.g., being left alone for extended periods of time, being left wet), or exploitation in nursing homes.

Solution. As part of a larger nursing home and LTC initiative, it is appropriate to suggest research on the prevalence, forms, and consequences of institutional abuse. It is time to separate sensation from science and determine the magnitude of the problem, resident risk factors, and LTC employee risk factors associated with institutional abuse. The President's recent remarks on this topic make the need for science in this area even more salient. With the likelihood of increasing numbers of LTC residents and the need for additional staff at all levels of resident care, it is critical to assess strategies and interventions that are appropriate for decreasing the potential for institutional abuse and neglect.

References

American Medical Association. Diagnostic and treatment guidelines on elder abuse and neglect. Chicago: AMA. 1992.

Becker G. Disrupted lives. How people create meaning in a chaotic world. Berkeley: University of California Press, 1997.

Berkman LF, Vaccarino V. Gender differences in cardiovascular morbidity and mortality: The contribution of social networks and support. *Annals of Behavioral Medicine* 1993;15:112-118.

- Breckman RS, Adelman RD. Strategies for helping victims of elder mistreatment. Newbury Park, CA: Sage, 1988.
- Chalk R, King PA, eds. Violence in families. Washington, D.C.: National Academy Press, 1998.
- Comijs HC, Pot AM, Smit JH, Bouter LM, Jonker C. Elder abuse in the community: Prevalence and consequences. *Journal of the American Geriatrics Society* 1998;46:885-888.
- Evans LK, Strumpf N, Allen-Taylor SL, Capezuti E, Maislin G, Jacobson B. A clinical trial to reduce restraints in nursing homes. *Journal of the American Geriatrics Society* 1997;45:675-681.
- Everitt DE, Fields DR, Soumerai SS, Avorn J. Resident behavior and staff distress in the nursing home. *J Am Geriatr Soc* 1991;39:792-798.
- Filinson, R. An evaluation of a program of volunteer advocates for elder abuse victims. *Journal of Elder Abuse and Neglect* 1993;10:77-93.
- Kayser-Jones J, Schell ES, Porter C, Barbaccia JC, Steinbach C, Bird WF, Redford M, Pengilly K. A prospective study of the use of liquid oral dietary supplements in nursing homes. *J Am Geriatr Soc* 1998;46:1378-1386.
- Lachs MS, Fulmer T. Recognizing elder abuse and neglect. *Geriatric Emergency Care* 1993;9:665-675
- Lachs MS, Williams CS, O'Brien S, Pillemer K, Charlson ME. The mortality of elder mistreatment. *JAMA*. 1998;280:428-432.
- National Center on Elder Abuse. National elder abuse incidence study. Final report. Washington, D.C.: Administration for Children and Families and the Administration on Aging, 1998.
- Phillips LR, Morrison EF, Chae YM, Steffl B, Cromwell S, Russel C. Effects of the situational context and interactional process on the quality of family caregiving. *Research in Nursing and Health*. 1995;18:205-216.
- Pillemer K, Finkelhor D. The prevalence of elder abuse: A random sample survey. *The Gerontologist* 1988;28:51-57.
- Pillemer K, Hudson B. A model abuse prevention program for nursing assistants. *Gerontologist* 1993;33:128-131.
- Rathbone-McCuan E. Elderly victims of family violence and neglect. *Social Casework*. 1980;61:298-304.
- Scogin F., Beall C, Bynum J, Stephens G, Grote NP, Baumhover LA, Bolland JM. Training for abusive caregivers: An unconventional approach to an intervention dilemma. *Journal of Elder Abuse and Neglect* 1989;1:73-86.
- Seeman TW, Berkman LF, Blazer D, Rowe J. Social ties and support as modifiers of neuroendocrine function. *Ann Behav Med* 1994;16:95-106.
- Suitor JJ, Pillemer K. Transition to the status of family caregiver: A new framework for studying social support and well-being. Pp. 310-32 in Stahl SM, ed. *The legacy of longevity. Health and healthcare in later life*. Newbury Park, CA: Sage, 1990.

Randolph W. Thomas
Criminal Justice Academy
Law Enforcement Instructor

Elder Abuse and Neglect: Forensic Medical Evidence

There are unique and complex issues regarding the collection of medical evidence that can be utilized by the criminal justice system. These issues focus upon law enforcement's recognized lack of expertise in the area of geriatrics and the forensic medical issues associated with the process of aging. Unlike child abuse, where the criminal justice system has established a medical base of knowledge that can assist in building prosecutable cases, elder abuse and neglect remains, very often, a mystery. The other pressing issue is the interface between the medical community and the criminal justice system. It is often difficult for law enforcement to obtain an opinion regarding a medical condition and its possible relationship to abuse or neglect. For instance, it is difficult in a neglect case where pressure sores are an issue to determine the relative time it took to advance from stage I to stage IV. Yet medical testimony as to how long this would take to reach that level (stage IV) could be critical to a neglect case. Expert medical opinion as to cause and effect is difficult to obtain and even more problematic if testimony is required in a criminal trial.

Effective case building in the emerging field of elder abuse and neglect must have effective forensic medical evidence. The ability of a law enforcement investigator to bring a case to successful resolution relies on a combination of experience and the ability to reach out to others who have the necessary expertise to assist in determining what happened and how it happened. Access to the medical community is imperative. It should also be clearly stated that the medical community must have the training and exposure to the forensics aspects of elder abuse and neglect to be of value to the criminal justice system. Consistent interaction between those two functions can produce the evidence necessary to hold an offender accountable. The fundamental problem often lies in the difficulty between identifying those medical facts that indicate abuse, and not those that are just the normal process of aging. The complex medical issues associated with aging, such as nutrition, use of medications, pressure sores, bruising, fractures, and other all too common conditions, can present the criminal justice system with difficult issues to present to a jury. Ultimately, any evidence collected by medical professionals might require presentation to a jury that often cannot grasp the complex issues. For example, it is difficult in many neglect cases to make a direct connection between medical fact and criminal intent. The relationship between nutritional deficits and the intent to deprive someone of food can be tenuous to a jury, thereby creating the reasonable doubt that defense attorneys utilize to their advantage.

It is imperative that the medical community and law enforcement develop a multidisciplinary approach to elder abuse and neglect. This concept has been successfully applied to child abuse and, lately, to financial exploitation of the elderly. This concept can include the development of a medical protocol, joint training, and joint staffing of complex cases. We have made efforts to accomplish this in South Carolina with the development of a medical protocol and training for those who may utilize this in developing a case. While we have not had universal success in training all those who might come in contact with a case of abuse or neglect, it has provided a common basis for collecting medical evidence. The problem now focuses on the fact that most cases of abuse and neglect are not presented at those locations that have the protocol available (acute care hospitals). We need to reach the general medical community in a more effective manner.

In conclusion, elder abuse and neglect cases present some of the most complex medical issues encountered by the criminal justice system. Unless we find an effective way to build bridges to the medical community that can provide the level of expertise necessary, we will always have major problems building effective cases.

Rosalie S. Wolf, Ph.D.
University of Massachusetts Memorial Health Center
Executive Director, Institute on Aging

Research

It is reassuring to learn from Sid Stahl that the National Institute on Aging is making a major commitment to research on elder abuse. More than 10 years ago, a panel was convened to review the status of research on elder abuse and to outline a future research agenda. At that time, priority was given to a prevalence study, validation of assessment and diagnostic tools, and evaluation of treatment and prevention programs (Stein, 1991).

Despite some advances in the intervening years, the knowledge base is still not mature enough to guide future policy and program development. Information is lacking not only about the intrapersonal and interpersonal dynamics and contextual and societal factors that lead to abuse, neglect, and exploitation but also about consequences of these acts on older people. Hundreds of adult protective services workers, criminal justice personnel, and others are handling thousands of cases yearly, but scant attention has been given to evaluating the effectiveness of their work and the services they obtain for clients.

As part of the workplan last year for the National Center on Elder Abuse, a workshop with almost 50 adult protective services administrators and a survey were conducted. Studies on intervention types, effectiveness, and program outcomes seem to dominate the findings, although a relatively large number of items were related to the criminal justice system, such as:

- How effective are criminal statutes, and what is the relationship to prosecution?
- What are the procedures for due process/notification? What works?
- How do criminal checks correlate with reducing risk of abuse?
- What are the effects of enhanced penalties/more prosecutions/background checks for elder abuse on incidence?

The need to learn more about the effectiveness of elder abuse intervention echoes the findings of the National Research Council/Institute of Medicine's Committee on the Assessment of Family Violence Interventions (Chalk and King, 1998), which stated that "rigorous evaluation for elder abuse interventions in any setting is almost nonexistent." To provide the necessary research base, the committee cited major challenges of study design, methodology, and logistics that have to be resolved but also emphasized the need for collaborative partnerships among researchers and service providers. A similar recommendation had been made earlier by a Panel on the Research on Violence Against Women, also sponsored by the Institute of Medicine (Crowell and Burgess, 1996).

In 1999, funds from the Centers for Disease Control and Prevention were awarded to establish a center whose mission would be "to help prevent violence against women by advancing knowledge about prevention research and fostering collaboration among advocates, practitioners, policymakers, and researchers." A series of focus groups was held across the country to find out how research can help practitioners (Seymour et al., 2000). While most had had some experience with data collection, they spoke negatively about:

- A degree of remoteness or even arrogance on the part of researchers.
- Insufficient attention of researchers to their effect on the victims.

- The practitioners' opinions were neither solicited nor respected.
- The inconvenience of participation.

The recommendations for practitioners and researchers from the focus groups were:

- Respect practitioners.
- Enhance mutual trust.
- Establish open communication.
- Reduce negative experiences.
- Acknowledge fundamental differences between those trained and working as practitioners and those working as researchers.

References

Chalk, R., and P. King. *Violence in Families: Assessing Prevention and Treatment Programs*. Washington, DC: National Academy Press, 1998.

Crowell, N., and A. Burgess (eds). *Understanding Violence Against Women*. Washington, DC: National Academy Press.

Seymour, A., L.M. William, P. Mahoney, and N. Shields. *Fostering Collaboration Between Researchers and Practitioners: Findings from Practitioner Focus Groups*. Charleston, SC: National Violence Against Women Prevention Research Center, 2000.

Stein, K. *Elder Abuse and Neglect: A National Research Agenda*. Washington, DC: National Aging Resource Center on Elder Abuse, 1991.

1 The views expressed herein are those of the author and do not reflect the views of the Department of Justice.

2 Existing data from State agencies on the prevalence of abuse and neglect in nursing homes would lead to an underestimation of the prevalence because some State agencies have low rates of reports (e.g., 1 allegation for each 1,000 nursing home beds), while many States tend to have very low substantiation rates (e.g., fewer than 10 percent of allegations are substantiated).

3 The opinions expressed herein are those of the author and do not reflect the views of the Department of Justice or the United States Attorney's Office for the Eastern District of Pennsylvania.

[Back to Top](#)

Transcript

Wednesday, October 18, 2000
9:00 a.m.

U.S. Department of Justice
Bureau of Justice Assistance
Main Conference Room 3102
810 - 7th Street, N.W.
Washington, D.C.

PARTICIPANTS

Ann Burgess, R.N., D.N.Sc., C.S., F.A.A.N.
Kerry P. Burnight, Ph.D.
Marie-Therese Connolly, J.D.
Carmel Bitondo Dyer, M.D., A.G.S.F., F.A.C.P.
Carl Eisdorfer, Ph.D., M.D.,
Charles W. Gambrell, Jr., J.D.
William E. Hauda, II, M.D.
Catherine Hawes, Ph.D.
Candance J. Heisler, J.D.
David R. Hoffman, J.D.
Ian Hood, M.D., J.D.
Mark S. Lachs, M.D., M.P.H.
Erik Lindbloom, M.D., M.S.P.H.
Patricia J. McFeeley, M.D.

Laura Mosqueda, M.D.,
Lisa Nerenberg, M.S.W., M.P.H.
Joanne Marlatt Otto, M.S.W.
Gregory J. Paveza, M.S.W., Ph.D.
Thomas H. Peake, Ph.D., A.B.P.P.
Karl Pillemer, Ph.D.
Susan M. Renz, M.S.N., R.N. C.S.
Arthur Sanders, M.D.
Sidney M. Stahl, Ph.D.
Randolph W. Thomas, M.A.
D. Jean Veta, J.D.
Rosalie S. Wolf, Ph.D.
Wendy Wright, M.D.
P R O C E E D I N G S

MS. VETA: Good morning, everyone. I am Jean Veta from the Department of Justice, and I'm delighted to welcome you to our Elder Justice Roundtable Discussion on Medical Forensic Issues. This is a very important event for us and, in fact, it is the first of its kind here at the Department of Justice. We feel quite honored to have all of you here with us today.

It is my pleasure this morning to introduce Dan Marcus, the Associate Attorney General. I'm happy to say that Dan is the person whom I have the privilege of working with every day. Dan joined the department in April of 1999 as the Principal Deputy Associate Attorney General and then became the Acting Associate Attorney General in October of 1999. The President's nomination of Dan was confirmed by the United States Senate in 2000.

MS. VETA: Prior to joining the Department of Justice, Dan was Senior Counsel in the Office of the Counsel to the President at the White House, and before that, Dan was a longtime partner in one of the pre-eminent Washington, D.C. law firm of Wilmer, Cutler and Pickering. As Associate Attorney General, Dan has responsibility for overseeing all of the litigating civil components of the department, as well as the grant-making agencies of the department.

I can tell you that one of the primary reasons we are all here today at this first-of-its-kind medical forensic forum on elder justice issues is because of Dan Marcus. His support has been critical in getting the — all of the department to move forward on this issue, and without his support, we wouldn't be here today. So, with that, I would like to invite you to join me in welcoming Dan Marcus.

MR. MARCUS: Thank you, Jean.

MR. MARCUS: On behalf of the Attorney General, let me welcome you here to the Department of Justice. We expect that the Attorney General will be with us this afternoon, which is wholly appropriate, because she is really, I think, the real reason why we are all here today. Under the leadership of folks like M.T. Connolly, people in the department have been working hard on these issues for a number of years, working closely with our friends at the Department of Health and Human Services and other parts of the government to deal with these cross-cutting issues. But it is the Attorney General who, I think, has really transformed the Department of Justice into a real Ministry of Justice. She has really led the way in expanding our horizons and recognizing that there are lots of areas like this, where the traditional activities at the Department of Justice need to be melded with social service programs and health programs and science and technology efforts to really provide a real comprehensive justice program.

I think in this last year of the Janet Reno regime, elder justice is really coming into its own in the Department of Justice as an area that will be important long beyond this administration. I want to welcome you this morning to this forum on medical forensic issues in elder abuse and neglect. We really appreciate your having made the effort, often on short notice, to give us the benefit of your expertise in addressing these challenging issues.

In selecting who should participate in this discussion, it was striking how many roads led again and again to the same names. You are a distinguished community of experts. That being said, not only are today's participants pre-eminent in their respective fields, but so too are the individuals who are here as observers, and we're delighted you all could come.

We only have a few hours today to discuss this complex topic, and so, in the interest of having a manageable, focused discussion, we have had to limit the number of participants, despite our desire to include many more folks. We hope, however, this discussion today will serve as a springboard to many more discussions with all of you and with a larger community of folks who are working in this field.

Let me tell you very briefly who is represented here today. You are geriatricians, medical examiners, psychiatrists, pediatricians, nurses, social scientists, sociologists and psychologists. You are experts in internal medicine, family medicine, emergency medicine, elder sexual abuse, developing forensic centers and in the forensic application of large amounts of clinical data.

You are the experts in elder abuse and neglect from the National Institute on Aging and Adult Protective Services, and you are prosecutors and law enforcement officials, representing federal, state and local agencies.

Many of you have done groundbreaking research in this area, developing creative multidisciplinary response teams and clinical practices and pursuing vital prosecutions and training efforts. People like Dr. Rosalie Wolf and Dr. Karl Pillemer have been pioneers for decades in the fight against elder abuse and neglect. We are very grateful to each of you, participants and observers alike, for joining us today in the exciting opportunity to lay the groundwork in addressing this difficult and important area.

The number of older Americans will more than double in the next 30 years. We have a long way to go in learning how to detect and diagnose elder abuse and neglect and obtaining consensus on what forensic markers demand additional inquiry and action. We have a long way to go in promoting multidisciplinary efforts at the national, state and local levels.

These efforts must include healthcare, social service, public safety and law enforcement professionals. We have a long way to go in educating those professionals about elder abuse and neglect, and we must urge them to conduct the research that will help us prevent, treat, intervene in and, where necessary, prosecute cases of elder abuse and neglect.

The goal of this roundtable discussion is to make progress in each of these areas and to promote the multidisciplinary efforts in which so many of you are engaged. We hope that today's discussion will give you useful ideas to take back to your respective institutions, to include in training curricula and clinical practices, to catalyze research proposals that will fill the gaps in our current knowledge and to promote funding of all of these efforts.

We also want to hear from you what you think we at the Department of Justice and in the government, generally, should be doing. There is so much to do that we must use our scarce resources that can be devoted to this area in a wise fashion. We have two moderators today: Dr. Laura Mosqueda, a clinician, researcher and educator, is the Director of Geriatrics at the University of California at Irvine, where she is also Associate Clinical Professor of Family Medicine. Dr. Mosqueda, who is board-certified in family medicine and geriatrics, is the principal investigator on a three-year project investigating the use of multidisciplinary teams for evaluation of elder abuse cases.

In another study, she recently completed the collection of pilot data on the national history of bruising in older people and what patterns of bruising should raise the suspicion of abuse. Dr. Mosqueda is also involved in education, having created a day-long course in elder abuse for geriatricians. In addition, she has testified in numerous cases relating to elder abuse.

As our second moderator, we have one of our own department lawyers, David Hoffman. David is an Assistant U.S. Attorney in Philadelphia. We call these folks AUSAs. He brought the first Civil False Claims Act case to address systemic abuse and neglect in a nursing home in 1996. Since then, he has settled five such cases. Perhaps the most significant remedies in David's cases are not the monetary damages, but the measures designed to protect residents; for example, the imposition of temporary monitors and other requirements to improve deficient areas in a single facility or chain of facilities.

Before becoming a federal prosecutor, David was Chief Counsel to the Pennsylvania Department of Aging. We are very grateful to Laura and David for their contributions to this effort. I would also like to thank M.T. Connolly, whom I mentioned earlier. She is coordinator of our department's nursing home initiative and has been a real leader in this field. I also want to thank the Office of Policy Development in the department, particularly Andrea Tisi, our Office of Justice Programs, which has not only lent us this wonderful room, but has really been helpful in organizing this event; Carol Cribbs of the Justice Management Division; and Pam Frank, our contractor.

I look forward to hearing about your discussion and to reading the resulting publication, which will include the papers and a summary of today's discussion. Now I would like to turn the floor over to Laura and David.

MR. HOFFMAN: I too want to welcome the forum members, everyone at the table and everyone in this room, because you are, in fact, invited guests. So, this is not an open party. You bring something to the table, while not sitting there, and we want to hear from you during our breaks, as well. If you have questions and comments, we would like to hear from the invited guests, as well.

A common theme that brings us all together here is the belief that elder abuse and neglect has to be addressed. It has to be identified; it has to be diagnosed; and, where appropriate, it has to be prosecuted, and the prosecution may be a civil prosecution or a criminal prosecution. In order to

facilitate this goal, we're going to focus on four discrete areas today. When you review the agenda, you'll see what I'm talking about.

The first is the detection and diagnosis of abuse and neglect. The second area is how health-care professionals and law enforcement can work together to solve the problem of elder abuse and neglect. The third area is educating law enforcement and health-care professionals on forensic issues relating to elder abuse and neglect. And finally, it is improving the forensic science through research.

So, I think all of us would agree that we have a lot of ground to cover between now and 2:30. So, I will be very brief. I just want to tell you what this is not about. This forum is not a training session. It is a full and frank discussion from experts. We brought everyone together, not to show how smart we all are, but rather to try to get to the best practices and get the ball rolling in terms of explaining abuse and neglect, what needs to be done and communicating that message throughout the country.

It is not a discussion on self-neglect. We all recognize that self-neglect is a big issue, but for purposes of our discussion today, we will not be focusing on self-neglect for remedy purposes. This is not a discussion about financial exploitation. We all recognize that elder abuse and neglect includes financial exploitation, but we will not be addressing that particular issue.

Hopefully, we will not be in a debate on definitions as to abuse and neglect, because we will be here forever, and we're not going to do that, either. So, we're going to go with the traditional model of physical abuse and neglect, as all of us have come to know it, whether through prosecution or through what you see in your practices.

This will not be a discussion about end-of-life decisions, okay. That is certainly out there, but we will not be discussing that today. Finally, this roundtable will not be about — it is easier for me to talk about what it is not about, in case you have not gathered that — not whether law enforcement is an appropriate remedy to elder abuse. We will say, given our position here at the Department of Justice, that law enforcement is an appropriate remedy to elder abuse.

Also, as Dan mentioned, as we go through our discussion, think about how this will play out when you go back to your various communities, your professions, your institutions, and how this can become part of a national plan, because we want to hear that from you, as well. Our procedure will be as follows: We have four lead presenters and you know who you are, and if you don't, it is too late and you will be called on. Our procedure will be the presenters will do three-to-five minutes, and we have a timer here, and now I'm going to bring the medical community into the legal world.

These were borrowed from the Supreme Court, so when this says stop, we really mean stop here on these things. So, this is by order of the Supreme Court. Green means go, yellow means you're running out of time and red means stop. Okay. So — and we do that because we're under time constraints. After that, after the initial presentation on each discrete issue, we will have a first responder, and those people know who they are, as well, to do follow-up. And then we want a full and frank discussion. We want to open it up.

I believe we will be calling on people, to the extent that is possible, but we do not want to sort of stifle any kind of discussion, so we will do it as quickly as possible. I think in the beginning we would like to have everyone introduce themselves, but, you know, there are 27 of us. So, that has to be done within about 15 seconds or less. But I thought it would be useful if we would just go around the table, who you are, where you're from and that probably will do it.

But I think that is how we would like to begin.

MS. CONNOLLY: I am M.T. Connolly. I have been coordinating the nursing home initiative for the Department of Justice.

DR. DYER: I'm Carmel Bitondo Dyer and I'm a geriatrician from Baylor College of Medicine.

DR. HAWES: I'm Catherine Hawes from the Texas A&M University in College Station.

DR. SANDERS: I am Art Sanders, Professor of Emergency Medicine at the University of Arizona.

DR. PAVEZA: I am Greg Paveza. I'm an Associate Professor at the School of Social Work at the University of South Florida.

DR. GAMBRELL: I'm Doug(sic.) Gambrell. I'm the Director of the South Carolina Medicaid Fraud Control Unit and a state prosecutor from South Carolina.

DR. BURNIGHT: I'm Kerry Burnight, a gerontologist from the University of California at Irvine.

DR. PILLEMER: I'm Karl Pillemer. I'm from Cornell University.

DR. STAHL: I'm Sid Stahl, Chief of healthcare Organizations at NIA, National Institutes of Health.

DR. PEAKE: Thomas Peake. I'm Professor of Psychology, Florida Institute of Technology and I'm adjunct at Florida Mental Health Institute in Tampa.

MS. BURGESS: I am Ann Burgess from the University Pennsylvania School of Nursing.

DR. LACHS: I'm Mark Lachs. I'm a geriatrician from Cornell Medical College in New York City.

DR. HAUDA: I'm Bill Hauda, an emergency physician, Falls Church, Virginia.

MR. THOMAS: I'm Randy Thomas. I'm a police officer and an instructor at the South Carolina Police Academy.

MS. OTTO: Joanne Otto, Adult Protective Services, Colorado.

MS. NERENBERG: I'm Lisa Nerenberg. I'm a consultant in private practice with experience working with community coalitions and elder abuse.

DR. WOLF: I'm Rosalie Wolf from UMASS Memorial healthcare in Worcester, Massachusetts.

MS. RENZ: I'm Sue Renz, geriatric nurse practitioner. I'm working as a federal monitor.

DR. LINDBLOOM: I'm Erik Lindbloom. I'm a family doctor and geriatrician at the University of Missouri.

DR. McFEELEY: I'm Patti McFeeley. I'm a medical examiner for the State of New Mexico. I'm also in the Department of Pathology, University of New Mexico.

DR. HOOD: I'm Ian Hood. I'm a forensic pathologist from Philadelphia and a newly-minted lawyer and the Deputy Medical Examiner in Philadelphia.

DR. WRIGHT: I'm Wendy Wright, a pediatrician from Children's Hospital in San Diego, California.

DR. EISDORFER: I'm Carl Eisdorfer. I'm a psychologist, psychiatrist, gerontologist, University of Miami.

MS. HEISLER: I'm Candace Heisler. I'm a retired San Francisco prosecutor and I now train and teach in this area.

DR. MOSQUEDA: Just a few reminders. One, I think we all now realize that we really do have to speak into the microphones, so please do so, so that everybody in the audience can hear you. Also, just to remind you, this is being transcribed, so, A, be careful what you say and, B, it will help for all of the folks to be able to hear us clearly.

I also would like to remind people that this is going to be leading to a presentation to the Attorney General later today, and one thing that we would like to have happen is for people to make some decisions as we're going along about what you want to bring back to your home office, so to speak, in terms of action items of what you may do, either new or different based on today's discussion, because that will be helpful to present to her later and something that I think I understand will be of great interest.

And I think with those comments, we'll probably move right into our first session.

DR. PAVEZA: I have one request. Could we have one of the monitors swung this way so that those of us on this side of the table don't have to crane our necks and sit back this way to watch the monitor? Is it possible to switch that monitor around?

DR. MOSQUEDA: Well, the only problem is the people in this audience will — are probably using that monitor, particularly because they have their backs to folks. So, the answer, I think, is no.

DR. PAVEZA: Yes, if that monitor could be swung just a little bit, then we could see that monitor over there.

DR. MOSQUEDA: You can also look right across and see people. All right. We're going to move on. And we will, at least initially, be trying to call on you by name to make it easier for the transcriber. So, forgive us if it sounds repetitive, but I think it will probably be helpful for all of us anyway to get to know each other.

So, with that, I think we will get our lead off hitter going. Since we're in the World Series, we can use that analogy and invite Dr. Mark Lachs to begin the first presentation.

DR. LACHS: Thank you very much, Laura. In keeping with the medical model, I brought some slides with me, four of them, in fact, and I will move through them very quickly, as I have been urged to do. If I could have the first one, please. I would begin just very quickly talking about another form of family violence. If I could have the first slide, please.

Just very quickly, this struck distract me as I was preparing for this morning. This is an article that was published in the New York Times about six or seven years ago, about a man in his 30s who had the bodies of his siblings who died in the early 1960s under mysterious circumstances exhumed. They were young children. The findings of that exhumation were findings that any pediatrician, any medical examiner in the year 2000 would have recognized as child abuse.

Many of you may have participated in this case. When they went back and pulled the death certificates of these kids who died in the early 1960 — for example, I think the three-year-old had a diagnosis of sudden infant death syndrome, which is just epidemiologically impossible. I show this slide first to say that I think the state of medical science and forensic science in elder abuse and neglect in the year 2000 is about where child abuse was, maybe not in 1960, but perhaps in 1970, when we began to sort of look at whether or not there were diagnostic injuries of child abuse and neglect.

Let me cut to the chase. The major issue, I think, in elder abuse and neglect in terms of the forensics of it is a higher burden of chronic disease, which is going to lead to, I think, a higher rate of false positives and false negatives. And I would just give a few examples. Osteoporosis, common syndrome in older adults, my emergency department will see five hip fractures, I suspect, today. What causes hip fractures? Osteoporosis. Could it be anything else? Sure, it could be, but I think there is a complacency that would preclude that.

Depression. Depression is a common syndrome in older adults and the tendency might be in this premedical environment to give medication for depression. Depression is a totally appropriate response to an abusive or neglectful environment. If you don't ask, you don't find out. Alzheimer's disease, about one-third of the patients with Alzheimer's disease, during the course of their illness, will have delusions. It's part of the illness. What are the delusions? People are breaking into my home. People are stealing my things. Well, maybe they are, and I think we really need to get on the stick in terms of trying to recognize that patients are telling us something, and I think we are ignoring those cries.

In addition to the medical issues, I think there are problems with ageism, both in society at large and in the medical encounter. I very quickly just wanted to show you some data from the new cohort, and I will very quickly walk you through it. This y-axis is survival. This x-axis is time. This solid line are individuals who had no contact with Protective Services over a 13-year period. They were on average age 75 when the study started.

After 13 years, the survival is about 40 percent. This middle line here, rather, are self-neglecting individuals. We are not supposed to talk about them, but they had survival of about 19 percent. And the lower group here are individuals who were victims of elder abuse and neglect. They had survival of nine percent. Why do I show this slide to illustrate ageism in the medical encounter? When I present this sort of data to internists, they say things to me like, "Mark, didn't these individuals have metastatic cancer, horrible, chronic congestive heart failure, terrible emphysema?"

And, in fact, when you begin to adjust for those particular issues, this number down here, after adjusting for age and chronic disease, the risk of dying after a period of elder abuse and neglect is about threefold. That rivals the death conferred for many, many chronic diseases, many chronic diseases.

In my own clinical practice, I cannot get older women to take estrogen because it confers the risk of breast cancer on the order of about 1.1 or 1.2. Here's an odds ratio of three, which is a stunning risk for death. And then, when one goes to look at certificates in these individuals, and this was sort of stunning to me and appropriate for a forensic forum, these are the no-APS group. These are the self-neglecting group. These are the mistreated group.

Physicians, when filling out death certificates, in no case in the mistreated group ascribed death to injury or poisoning, but there was a slightly higher prevalence of symptoms of signs of ill-defined conditions, really sort of fascinating. I think there is an enormous opportunity, an opportunity to really look at index conditions that this group could talk about to identify elder abuse and neglect.

I see that my time is up and I will stop my comments there. I got through my first slides. Thank you.

MR. HOFFMAN: Thanks, Mark. Listen, in talking about the identification of specific medical conditions that warrant further review, in most, if not in all cases, we are sort of trying to figure out what would trigger a further review and then discuss what that further review would be about. And I would ask Dr. Hood to talk about, based on your experience, Dr. Hood, the kinds of things from what you have seen, conditions that would warrant further review in terms of the practice of medicine.

DR. HOOD: I have reviewed some of these in my paper presentation, but obviously there are things we're used to seeing that make us think about abuse and they unfortunately occur routinely in fragile, elderly people and are not necessarily indicators of poor care. There is, unfortunately, no absolute pathognomonic condition that says this person was abused, absent, that is, outright assault that any forensic pathologist or indeed any physician could see as such. But fractures of long bones, fractures of ribs, almost always or should be an indicator for further investigation. A fracture of a hip, a fracture or a collapse fracture of vertebrae may not.

Decubitus over areas it is almost impossible to get somebody off of, their sacrum, their hips, if they have been adequately documented and appropriate wound care taken but it has still progressed and may not be an indicator of improper care or neglect. Decubitus that have been allowed to progress without proper documentation or referral are an indicator of neglect. You have to go and evaluate them for that. Decubitus that occur in areas that you could easily protect, such as knees, ankles, heels, or against urinary catheters that could've been protected are an indicator of poor nursing care and may well be an indicator of neglect.

If you see those, that is enough to say they need further investigation. Any kind of bruising in an elderly, fragile individual does not necessarily mean neglect or abuse. One of the toughest calls to make, and that is why we have just had this national study done, is first off is it a bruise, and if it was a bruise, was it obtained innocently? Frequently, clinicians never even think to address that issue. Forensic pathologists only get involved in a point in time when it is too late.

Obviously, it is often said of us that we know everything and do everything, but one day too late, and it is unfortunately true. We do have a part to play, though, in terms of the presentation of evidence. Frequently, if you're a lawyer and you are faced with pursuing or prosecuting a case, you will find that the forensic pathologist is your most practiced presenter of evidence and a good person to go to as a reference person to be your witness, even if you may be dealing with a living patient.

And unfortunately, Dave has begun to learn that about the forensic pathologists in Philadelphia. We're also blessed there with having a very active forensic nursing unit, which Dr. Burgess is in charge of, and they are proving their worth in that regard, as well.

DR. MOSQUEDA: Now, we would like to really open it up to discussion. As David mentioned, we are interested to hear — one thing I'm interested that I think the legal profession keeps asking is are there any types of indicators or markers where you would just say no doubt, this is absolutely abuse? And, if not, what markers would make us go toward further investigation and what would that investigation be? So, we will throw it open for discussion.

Dr. Burgess?

MS. BURGESS: I would like to add to Dr. Hood's list. In the sexual abuse area, what we have found is certainly suspicion — I cannot say they are absolute — but sexually transmitted diseases found in a nursing home resident. Urinary tract infection is a soft marker, but for example, if all of the

residents in one room who are all being cared for by one aide or something like that might certainly be plea raised.

Bleeding. I think that bleeding, I know, was mentioned in Dr. Hood's markers of certainly being suspicious. Vaginal bleeding. Bruising, the pattern of bruising to the abdomen and pelvis area has certainly been seen in the cases that I have analyzed. And it is a particular patterning. It is not like, you know — it's really to the abdomen, where a massive amount of force has been used to the abdomen, and you'll see the pattern.

DR. MOSQUEDA: This is in sexual abuse cases; correct?

MS. BURGESS: Yes, I'm talking only in sexual abuse cases. Those would be the more markers. The psychological markers that we have seen are the fear and — you'll see this in the nursing notes — fear of males especially, the sexualized behavior onset, new onset of these kinds of behaviors. You certainly see the other, the withdrawing, the hypersomnolence, the depression. But it is more of an almost traumatic shock has been the way I describe it. They just go into a very different mode after the abuse.

MR. HOFFMAN: An area that I have seen in my prosecutions involved malnutrition and dehydration. I was interested in hearing from the medical experts those particular areas of what does that trigger in terms of response to profound malnutrition or dehydration in older adults? Any thoughts? Dr. Dyer?

DR. DYER: Well, you know, those should trigger some action, but sometimes they are not due to mistreatment and are instead a result of cancer. Not every malnourished person - some people choose not to eat. However, I think we should have an increased index of suspicion in individuals who have dementia, who have depression, who have psychosis, who can't otherwise take care of themselves.

So, if we see those problems, we need to at least consider elder abuse. The other thing is that as every good gerontologist knows, is you need to get a collateral history and you have to look at the whole picture. So, we all must have an increased index of suspicion for elder mistreatment, but to really confirm abuse, we need to talk to other involved and we need to look at the elder's social situation, functional situation and home situation.

MR. HOFFMAN: Carl, go ahead.

DR. EISDORFER: I would underscore the last remark. I think a lot of this has to be done in context, short of doing a blood test and looking for an abnormal level of drug or poison, most of this stuff really is contextual. So, I think we're very appropriate in talking about the high relative prevalence of false positives, but I think there's also going to be very high false negative rate, particularly because you have this problem going in both directions, and let me make just one or two comments. Severe decubitus in a nursing home setting should raise everybody's index of suspicion, particularly since they can be lethal.

That is the kind of thing that any good nursing home should be very sensitive to, but other issues, depression being a good example, depression is a treatable condition of someone chooses to treat it. And depression, in turn, will lead to the possibility of malnutrition and so on. On the other hand, if somebody is not fed, they are going to get malnourished.

These are the specifics of the theme I would like to indicate. So, I think what it really seems to me we have is the need to establish, A, the preconditions for whatever it is we find, and I will give you

another example. Clearly falls in older people would lead more likely to broken bones, but if you have a pattern of falls in a nursing home, then you know that there is some kind of neglect, because patients should not keep falling. So, again I would emphasize the collaboration between the forensic and the clinical scientist.

DR. MOSQUEDA: Greg Paveza?

DR. PAVEZA: I'm going to go out on a bit of a limb and go back to David's first question, which is I know of no incontrovertible piece of evidence that would suggest to me that this is abuse and only abuse. Nothing in the epidemiologic studies I have seen has such a huge odds ratio or risk ratio that you can say if this shows up, you absolutely know it is abuse.

I mean, we're talking about odds ratios of two and three, and while they are strong, it does not say there is a likely cause. Kind of one of my issues is, if you see depression, to use the classic DSM4 phrase, in the absence of any other reason for why a person would be depressed, one needs to consider the fact that the person may be being abused or neglected.

But they're just isn't anything that says that's it. If you see it, you got it. Do something about it.

MR. HOFFMAN: Dr. Lindbloom?

DR. LINDBLOOM: Getting to the dehydration and malnutrition question, my own research right now looks at death certificate data from 1997 in our own State of Missouri, including all the death certificates with dehydration and malnutrition either as a primary or secondary cause of death. I found no postmortem exams or other investigation after the fact. So, not to say all those cases should have been autopsied, but I think I would echo the sentiment that there needs to be some evaluation ahead of time or at least at the time of death to assess a level of suspicion.

MR. HOFFMAN: Well, let's follow up with that, because I think that dovetails into part of the discussion of what needs to be done to address that, because I think we have all seen that on death certificates with no follow-up. What should be the protocol in that regard? Dr. McFeeley?

DR. McFEELEY: Well, speaking from a medical examiner point of view, essentially if someone dies of anything that is not entirely natural, it really should be a medical examiner case. But you know from death certificate data they are not being picked up. Many of them are not even being seen or referred to a medical examiner. We get cases referred to us for a fractured hip because it may be an accident, and those cases are often reviewed by paper, often because they're not reported at the time of death and there's not even someone to examine, if there was.

But deaths in a nursing home, as the nursing home says, they are expected. They are not even evaluated unless there really is an issue. So, I think your death certificate data is very poor. I look through the literature and there's one of the articles in the forensic literature talking about homicides in the elderly, ages 65 and up. In this 15-year study, they evaluated two cases they documented as abuse — clearly more than that in a very large county with a high population of elderly people.

So, I think although death is not your only criteria, and that does not make it easy just because they died. One would think that is easier than some of the people who have lesser injuries, for instance, it is still a very difficult diagnosis to make. But until you start looking at those people, you're never going to get any kind of data as to what the percentage are that die, and that is only the tip of the iceberg.

It's like in child abuse, it's important to look at and to evaluate the deaths because you learn something about the less significant injuries, but until you do that, you're not going to really have a handle of what the incidence is.

MR. HOFFMAN: Dr. Nerenberg?

MS. NERENBERG: I'm not a doctor, but thank you.

MR. HOFFMAN: I will call everyone Doctor. How is that as a deal, just to be safe?

MS. NERENBERG: I just wanted to get back to the issue of context, and we're focusing here on medical indicators, but oftentimes we need to look at other nonmedical indicators, in particular capacity issues. For example, in assessing an alleged rape, often whether or not it was a rape or not gets down to whether or not the person had the capacity to consent to sexual relationships.

Capacity is a very complex issue and many medical professionals are starting to get a handle on decision-making capacity for certain things, including end-of-life decisions or capacity for medical care. In elder abuse cases, we're looking oftentimes at different kinds of capacity. There is a lot less work that has been done in capacity, for example, for sexual contact, what level of decision-making capacity you need.

It has been looked at with younger populations, but not so much with the elderly.

MR. HOFFMAN: I would like to follow up to what Dr. McFeeley has said, in terms of how do we sort of back up when we get to malnutrition and dehydration. And at least it has been my experience that whether residents of institutions or in the community, there are visits to the emergency room prior to the last visit, prior to somebody dying.

The question I would have for those of you in the emergency room crowd who are a part of the table are what are you seeing, what are the triggers and how is it we could maybe address or start responding earlier before it turns into profound malnutrition and dehydration?

Dr. Sanders?

DR. SANDERS: Well, the way I think we need to approach it is kind of in Mark's presentation and his abstract, false positives and false negatives. We do this in other areas of medicine, depending on resources, where you set the bar. And I don't think it is only in emergency departments. I think primary care practices, orthopedic practices, et cetera. One, we need to do better research to find out what are the indicators and how sensitive is long-bone fractures or bruises or dehydration or things like that or a combination of the factors.

That is one level of case finding that would lead to — it seems to me that in general where elder abuse is detected, it is from a multidisciplinary group that goes out and does home visits, follows a patient over time and then makes a decision. We do that in clinical medicine. Nobody comes in exactly with a textbook presentation. We put various factors together and we say, "Well, I think the odds of having this are better than the odds of having this," and therefore you give someone a label or a syndrome or something like that.

So, using that same context, I think there needs to be an initial level of screening. Emergency departments, primary care practices, other subspecialties, and then a more comprehensive level of screening which involves, as people have talked about, these multidisciplinary groups, geriatric assessment units which involves law enforcement, social services, medical direction, et cetera. And

they will make that final decision about both treatment of various conditions, as well as whether the Justice Department needs to get involved in terms of prosecuting people.

DR. MOSQUEDA: Yes, Joanne Otto?

MS. OTTO: I'd like to follow up on something Lisa said in terms of context and to put in a plea for common sense. We recently had a situation where in one month's time two very demented, bed bound women in the same facility showed up with vaginal bleeding and tearing. And the decision of the charge nurse was that it was self-induced and one wonders how that can happen.

So, just think about is it possible.

DR. MOSQUEDA: Catherine Hawes?

DR. HAWES: I'd like to follow-up on that, because I see a lot of pictures of residents who were bruised, and it looks like defensive wounds to me, where they have held their hand up and their face is beaten and they have flung themselves against the bed rails repeatedly, according to the nursing home. There are things like that I think it is right to talk about the more things that are the index of suspicion, that are not obvious.

But when you see residents who have clearly been beaten up or scalded or who have severe malnutrition and they are from a nursing home and you see repeated cases, those are not getting picked up either, so it is not just the kinds of subtle things that people might miss and think are normal aging, it is also things that I think most of us believe are obvious.

The second thing is to follow up on the context. You know, if you look at the MDS data from nursing homes, you'll find that rates of malnourishment for people without an explicit terminal prognosis range from eight percent of the residents to 27 percent of the residents. And there are facilities where nearly one-third of the residents have severe undernutrition. So, the suspicion ought to be just not individual cases, but also patterns of care.

DR. MOSQUEDA: I think that is a great point. When we're talking about facilities, is there any method to know that if people go to multiple different emergency rooms, if there is a pattern in a facility. But I think we certainly all would agree that some of the markers — it doesn't matter if it's in a nursing home if there has been a scalding or if you live at home, that we need to be concerned about abuse really in all settings, and we do not want to turn this into a nursing home based conference.

So, I think one question is there anything different in terms of abuse at home versus nursing homes that would make you suspicion one place and not another, and the other, I think, important question is that this all sounds well and good. I mean, it is nice to sit here at this table and say, "Well, gee, if somebody comes in with this pattern of bruising, we need to look further."

But let's also talk about what we know is the reality in that office practice, in the busy emergency room, is that going to happen and what really ought to happen if somebody comes in and has maybe not these really obvious markers like a scald or a cigarette burn, but has something more subtle, bruising on the forearm in a maybe slightly unusual location where somebody has an explanation for it. What ought we to do?

Sue Ren?

MS. REN: Laura, you brought up a good point because as you were speaking, I was thinking about how far we have come, hopefully, within that last 10 years. When I think about 1990 in Philadelphia, and Dr. Hood can speak about this, too, the case of Elizabeth Ellis, who was a woman who had probably 17 or 18 ER admissions through at different hospitals throughout the Philadelphia area and eventually ended up dying of sepsis from decubitus ulcers, dehydration, malnutrition and severe contractures.

And it wasn't until a temporary nurse in one of the emergency rooms who was doing a tour in a new hospital recognized that there was something wrong with this person and said, "We need to call the police. We need to find out what is going on with this resident at this nursing home."

And I would hope that we could talk about today that — I know it is difficult in emergency rooms situations to really look at those indicators, but we need to move in that direction that we're going to look at those indicators that we have already talked about, the bruises, the fractures, the dehydration and malnutrition, if a person comes in and looks like they are malnourished or their labs indicate that they have protein calorie malnutrition or severe contractures and try to distinguish what is the difference between the normal aging process concurrent with disease and abuse or neglect.

And we have done education throughout the country to health-care providers about what those indicators are, but it has to continue and people have to stop, as Dr. McFeeley said, and take a look.

DR. MOSQUEDA: Do people here believe that it is the physician's responsibility, be it an emergency room physician or the primary care physician, to do that further investigation, and what resources do they have available?

Dr. Wolf?

DR. WOLF: I just want to mention that there is, I think, the practice of trying to do some universal screening of every older person who comes into the emergency room. There now are some studies which should be considered. Have tested a screening tool of five or six questions, that might help you. Now, it is true that the person may deny and the older person may not be able to respond, but a skillful practitioner should be able to work around it and to come up with some level of suspicion.

MR. HOFFMAN: Dr. Lachs?

DR. LACHS: Laura mentioned the role of the primary care physician. I just can't say enough about this. For older adults, often socially isolated — for child abuse, I assume there is some modern-day equivalent of a truant officer that, you know, you come to school with a bruise or you don't come to school, and you make it into some system that identifies a child. For an older person, that annual visit to a physician may be the only contact that individual has with someone outside of the abuse or victim dyad — I mean, that is so compelling — or with that emergency physician for one particular visit and yet physicians practice in an environment which is increasingly hurried, the role of not only professional education, but allowing time for these complex evaluations, which cannot be done in a six-minute managed care visit, I worry deeply about.

MR. HOFFMAN: Well, let's hear from Dr. Gambrell. Just kidding. Bill?

DR. GAMBRELL: I do want to address the issue of notice, and Randy Thomas I think has brought with him — we have done in South Carolina basically an adult abuse protocol where we attempt to educate the various health-care components by going on ETV programs and doing other sorts of things. And while I cannot claim the success ratio is particularly high with respect to that, I think

that is a vital component that is necessary that can come from law-enforcement and a prosecution arm in providing some assistance in doing that, so that there is some awareness and some option where people know where to call or when they have a suspicion know whom to contact. I think that is extremely valuable.

MR. HOFFMAN: Randy, to follow up?

MR. THOMAS: It provides a structured way for physicians to screen for possible suspected cases of abuse or neglect. It also capitalizes on a system that we have used for long time in South Carolina in child abuse. And so, our law-enforcement people are familiar with the forensic package that goes with this, and that is a real advantage. You get that mind set and, as talked about, it is in context.

They are familiar with the fact that this is an evidence collection issue and has to be handled properly. And I did something I am going to leave with you to take a look at.

MR. HOFFMAN: Dr. Wright?

DR. WRIGHT: I think I just wanted to say two quick things. One is my perspective is a little different. Being a pediatrician, I feel like I'm sort of on the outside, looking in. One of the things in my work involved with elder abuse, it has struck me, is the appreciation — not appreciation, but the acceptance of death in older people, I think. If a young person dies, everyone says a young person is not supposed to die. We better figure out what happened.

If an older person dies, someone says, "Older people die. They must've died from old age, from whatever it is." So, I think that at the beginning, the appreciation for the cause of death in older people really needs to be investigated. I am echoing, I think, what Dr. McFeeley said about the need for autopsies. I think that a lot of medical practitioners are unwilling to report potential cases of physical abuse or abuse, in general, in elders because they don't feel like they have the support of the medical literature behind them, that if it becomes involved with law, they don't know what medically is acceptable or not acceptable.

And that is because that body of evidence does not exist in elders in terms of hallmark — what we were talking about, actual forensic markers. I think that just like sudden infant death syndrome or shaken baby syndrome in children, until we started doing autopsies on children that died, we did not realize that there was a difference between the two, and there could be a constellation or a pattern of injuries that you see in elderly people that could be a forensic marker, but currently is not being recognized because of the lack of information after death.

The other is, just real quickly, is that I think it is very difficult when you're approaching a problem to want to do everything at once. For instance, in child abuse, we have shaken infant syndrome on one spectrum and, for instance, perhaps a failure to thrive on the other. One is them is a hallmark, slam dunk, pathomnemonic child abuse and the other is that constellation of psychosocial factors, medical disease in a child, which may or may not be abused.

And I think that, from my perspective in dealing with child abuse, sometimes you're better off going for the big bang for the buck in trying to come up with a pathomnemonic diagnosis or things that are much more likely to be physical abuse, people can start with that and hang their hat on it and then work their way into some of the more complex social situations, which are very difficult.

It seems like that is where everyone wants to go to start with. They want to start with the malnutrition and the nursing home, but that is the most complicated social-medical situation to start with, yet you have elder people dying with 49 broken bones, four Stage IV decubitus and subdurals,

and those aren't getting prosecuted because there's not a physician who is willing to go to court and say that had to have been abuse.

So, I think that would be my slant, in terms of looking for forensic medical markers to try and get a better body of information and maybe that starts with autopsy findings and start with some of the easier cases, if there is such a thing.

MR. HOFFMAN: Dr. Pillemer?

DR. PILLEMER: I would just really like to second that. I think the problem is made incredibly more complicated by the undifferentiated treatment of different kinds of abuse and neglect, even as it is worded here. And it seems to me, what I understand as a nonmedical person from the conversation so far — it seems to me to be how do we establish abuse in a very specific kind of a situation, namely where the victim is incompetent and can't give an account and nobody has witnessed the actual abuse occurring, and in particular in cases of malnutrition or dehydration where in every case there is a potential perpetrator, whether in an institution or at home, the person will almost invariably have another explanation for why the event occurred.

I think that those cases provide, both from a research perspective, if you're looking for risk factors, and I'm sure from a forensic perspective an almost impossible challenge in the state-of-the-art that just is not there. I absolutely agree that if it is possible to focus on risk markers for essentially places where they are easier to establish, like in cases of physical abuse, in cases where the elder is competent or somewhat competent, I think that makes an awful lot of sense.

I think we complicate the problem for ourselves excessively by talking about elder abuse and neglect in a setting like this, even in meeting somebody who suffers from dehydration to somebody who has been raped and brutally beaten, I think it just makes the problem almost impossibly difficult.

MR. HOFFMAN: Dr. Lindbloom?

DR. LINDBLOOM: I would also like to emphasize from a primary care perspective, the importance not only of contact with the primary-care doctor, but the lack of contact. Frequent missed appointments, for example, or mildly demented elders coming to clinic alone, maybe put on public transportation to get to their clinic appointment with no one accompanying them - I found that, over the last few years, to be relatively sensitive for a neglectful or abusive situation at home.

DR. MOSQUEDA: Dr. Hood?

DR. HOOD: I would like to echo what obviously is a common theme, which is we have a pyramid of cases in terms of how sure you are that they are neglect or abuse. You have a tremendously-wide base of cases that present to all of us in all aspects of clinical practice where it is not enough to do much more than just say this could be something suspicious. And finally at the top, you have what the legal side wants. You have an identified victim. You have an identified and charged perpetrator. You have evidence and you have a witness who can present it. Now you're ready to go and get a successful prosecution.

For every one of those, there is a huge base of patients that are seen only briefly and who have raised a suspicion on somebody's part, whether it be a nurse in an emergency room, whether it be a social worker, a family physician who has just had his HMO-allowed six-minute interview with a patient. What you need to deal with that is correspondingly a hierarchical system of how you will refer and investigate those cases.

So, the large base — need to have something simple and easy that the person who is suspicious can do. There is no point calling in law-enforcement at that point. Certainly if you were to do that in Philadelphia, you would be referred to a detective who would simply say, "What breach of the law has occurred?" And if you can't tell him, well, that is fine, a 48 will be filed and it will be the end of that.

You do need to have a hierarchical system. It will vary, depending on your own individual state and county set-ups as to how it will start. It may be that you have a very good Adult Protective Services, with a large ombudsman base and you can just call a hotline, call the ombudsman and nothing more may happen. Or you may go further up to the point where the health department or whoever is in charge of licensing the nursing homes or personal care facilities will intervene and do some kind of inspection and monitoring.

It is at that point, I might add, that particularly forensic pathologists and coroners and medical examiners can get into the issue, you can use them because one of the things you can do is what we've done in Philadelphia, where you have had one incident in a particular nursing home or chain of nursing homes, as a form of monitoring you can now say you're not allowed to sign your own death certificates. Anyone who dies in that institution must now be referred to the medical examiner's office.

And that is basically all we do. Any case coming out of those nursing homes or institutions — and they are mostly, I might add, personal care facilities. There is a distinct difference. They simply get a relatively straightforward examination at the medical examiner's office. If we had autopsy all of them, we would not be able to do it, either. But it is relatively easy to start a case file, undress them, take all the dressings off whatever wounds they may have, clean them, straighten them out, something that could not be done in life, and photograph them.

The mere fact that was done on every case that died and came out of the nursing home and the fact that they know that it was being done is remarkably effective at maintaining awareness in that nursing home or personal care facility that they are being monitored and that alone is all you need.

DR. MOSQUEDA: Dr. Eisdorfer?

DR. EISDORFER: Just a couple points. Dr. Wright opened up a critical issue. Old people die. They are much more likely to die than are any other age group, and so we have a context effect, because not only are they dying, but they're seeing doctors, a lot of old people seeing, arguably, a lot of doctors. And so, the question then is what is the index of suspicion on the part of the physician, that this particular older person is more likely to be abused than the other 100 that they have seen in this now classic six-minute hour.

The belief, I think, on the part of physicians — and it was true of all of us, including pediatricians, 35 or 40 years ago — was that families do not abuse their own. Child abuse, for example, we keep trying to forget, is relatively recent as something that is under suspicion on the part of emergency room family practitioners. Let me give you a couple of context areas. We have believed that older people have suicide pacts. It is a widespread belief.

Well, Dr. Cohen and I have been looking this problem for about five or six years. We discovered there are very few suicide pacts, and, in fact, we have very good reason to believe that it is violence perpetrated against women, because a lot of the times it is almost invariably the husband who does the killing of the wife with a gun and the bullets are going through the wife's hand.

But there also some indications of the husband, his precondition. The point I'm trying to make here is for the forensic pathologist, it is a no-brainer at one level. They can see a bullet wound. They can

see the second bullet wound. There may be a statistical problem because you have two deaths very often uncorrelated unless you go to the raw data and then you link them, and that makes a statistical problem, but the more important thing is that only by a psychological autopsy can you recognize that, okay, now you have got a coupled problem and very often there are predictive factors.

So, I think one of the things we really ought to do is to broaden the context of the autopsy from a purely physical pathologic to more a psychosocial thing, because I think what we're talking about now again — I hate to reverse it — is the context, and there are indications one might say could be looked at in looking at a death or a battering of an older person.

DR. MOSQUEDA: I think that what is happening here, what we're seeing is research, education and practice all coming together, because we have to — again, if we want to get practical and have something like Dr. Hood's idea, that sort of model, set up for the practitioner in the office, if somebody comes in with a bruise that might be just suspicious and is not an obvious sort of abuse, I think we've answered what do we do, which is typically not much.

But now the question is what ought we do, again, keeping the real world in mind, which is we do tend to have very short office visits. Is it reasonable to expect or even ask a clinician to do a more thorough evaluation, and the answer to that might be yes, it is. And then, if it is not, what resources need to be created so that more of an evaluation can be done?

Dr. Peake?

DR. PEAKE: I'm struggling some with the medical and the psychological kinds of issues. In the State of Florida, we have, I believe, 13 what are called memory disorder clinics. And it is an interesting concept. It is a wonderful training setting for our doctoral students. What we found in the community is that people will come to this clinic where we end up doing a short cognitive evaluation, a thorough medical history. We look at the family. We look at their history. And so, in about an hour-and-45 minutes, we've got a pretty good screening of a lot of areas.

We do a triage every week, probably we screen 25 or 30 folks a week. The doctoral students and the medical students are involved with this, but what we find is even though that is not the medical kind of abuse that we're talking about, but we may overlap with that, people will come here who will not go to other places. If they say, "You know, Grandma, we're going to take you to see the doctor, your memory is not so good," they won't go.

But they will come here, and we end up picking up all kinds of things, and then we begin to develop to get referrals from the psychiatric hospitals, from nursing homes and so forth. People come every year for this re-screening. The snowbirds who come down every year, come and make it an outing for these kinds of screenings.

So, this does not solve all of it, but we have found it to be a way to get people to come into who like the young people who are screening. We go through this. We have this information and it may be a model that could be a useful one in terms of can you set a place where people can go — the old notion of primary or secondary or tertiary kind of prevention.

DR. MOSQUEDA: Right. So, one opportunity might be where we can do screening and then we're still going to get to the, "Then what?" question in terms of evaluation, but that might be a very good model for picking up.

DR. PEAKE: Well, the other thing we talked about is that primary physicians do not have the time to do it, and then that becomes a referral of the agency to ones that can follow up because you have got the information to justify more of a thorough investigation.

DR. MOSQUEDA: Joanne Otto?

MS. OTTO: Well, there are 44 states that have mandatory reporting of elder abuse, and in every state that I know of, physicians and other health-care professionals are mandated reporters in those states. And yet what we see, Mark talked about the fact that almost every elderly person goes to the physician more often than he goes probably even to his preacher, less than 10 percent of the referrals are coming from the health-care professionals.

So, I'm just kind of wondering is there a problem for APS and the health-care folks that we're not communicating?

MR. HOFFMAN: Well, I think we want to still be moving towards what needs to be done, so we have gotten some markers. What is incumbent in the responsibility? We have a mandatory reporting environment, so there is where the legal requirements are, and yet the reporting on the data that I have seen, the reports from the health-care professionals, especially physicians, is extremely low.

Those cases are not being reported and I think there is a process going on, and I cannot speak for physicians, "Well, I'm not really sure. I don't know what's going on here. I suspect these are indicators, but I'm not going to make the report, because then I got brought into the system and I may have to testify. There may be other things that go on, when I'm really not sure." So, it gets processed out and there is no further investigation.

So, again, we're back to we have indicators; we have some markers that everyone has talked about. What occurs next?

Dr. Sanders?

DR. SANDERS: I think for exactly those reasons and for the reasons that the other system has failed, we cannot expect the front-line physicians to do it, whether it is primary care or emergency physicians, to do a complete work-up. What we can ask is they detect — I like the analogy of the pyramid — they detect the bottom part of the pyramid, and it is easier in child abuse, because there are pathomnemonic signs.

But the discussion was great in terms of saying it is just not clear and it is not an easy thing to do, plus I don't think most primary care physicians or emergency physicians have the expertise to sort it out. So, it is a very complex issue, that — if we needed to find what they need to do, and it is probably something like I said before. It is basically take high-risk criteria that is well-defined and then the educational thing will flow from that — it is a simple thing — and make a call.

Now, it has to be part of a system. You know, if you do CPR in a small town in Honduras, the patient is going to die because it is not connected to a system that will go out and investigate, do the home visits, do a multidisciplinary geriatric assessment, et cetera. So, the whole system has to be in place.

DR. MOSQUEDA: I'm just going to go to another medical person quickly, and then we'll go to Lisa and to Greg.

DR. WRIGHT: Just real quickly to speak to that, I think that is an excellent point, is that in my community, at least, and in a lot of child abuse communities, the people who do forensic child abuse

work like myself feel like we have actually spoiled our medical community, in that my regular pediatricians in the community won't even report a belt-bruise that they see on a little kid because they feel like it is out of their area of expertise.

What they can do is call me in a heartbeat. I will see the child, do the whole forensic evaluation and then do the reporting, do the documentation, go to court. So, it eliminates the responsibility of them to follow up on some things. It increases the reporting because they feel like they have some backup in terms of medical expertise to go to.

The biggest question that comes of that, though, is the remuneration for the services, how do you find someone or pay for the services of the forensic expert, if you will, and that is a question that child abuse is struggling with across all sorts of — everywhere throughout the nation. And it is done very differently, and I think one of the things we have to think about is if we're going to legislate reporting of elder abuse and we're going to legislate investigations and prosecution or, at least, talk about legislations of exams and things like that, we have to also include in it funding and some streams of resources to the people who are going to have to do that work.

DR. MOSQUEDA: Lisa?

MS. NERENBERG: I wanted to make the point that you really can't look at the medical indicators totally in isolation. You know, we're starting to see now sophisticated fraud investigators who are seeing situations where — you know, sweetheart scams or somebody they believe is being ripped off financially, where they are starting to investigate whether or not the person is being physically neglected as a way of hastening their death or that they are being even poisoned. We're starting to hear reports of that.

And so, when a medical examiner sees a neglect situation or a situation where medications are being mismanaged, they need to know what is going on in the home. They need to know who the care giver is. Is it a care giver who is well-intended and simply not trained or over stressed to the point where they cannot provide good care, or is this the wife of two months or is this a child that stands to inherit?

So, I really want to reemphasize what Joanne is saying, that physicians, medical professionals, need to make reports to the folks that can go out and do these broader kinds of examinations.

DR. MOSQUEDA: Greg Paveza?

DR. PAVEZA: There are a couple of things which I think all fit into this concept of what ought we to do. First of all, one of the issues that I see as being critical is we need to expand beyond physicians, per se. One of the issues that we have not talked about, for instance, is the large number of professionals, social workers and nurses who engage principally in home healthcare, who are a prime set of people to identify abuse and neglect.

A lot of the discussion right now has really gotten to the point of so they show up dead, what do we do? Well, you know, my background is in public health and I would like to think about the fact that there are a lot more alive people who are being neglected and abused, then show up in our offices or in our medical examiner's offices, and we need to be aware of those folks.

Law enforcement needs to be included in this process. While in Philadelphia, it may go to a detective, I can tell you I have ridden with beat officers who get calls on a regular basis to go out to homes because some neighbor dials 911 and says, "Do something." And that beat officer spends

four hours at a home waiting for a APS to show up, because it takes that long for an APS worker to get notified that they need to do an emergency investigation.

We need to be prepared to use the system, and I realize that the system is not perfect, but it is one of the excuses that most of us in the health professions use for not reporting to APS, which is APS is not going to do anything. To some degree, APS cannot respond to that , and that is a critical issue.

MR. HOFFMAN: Okay. I think we are at a point in the break. Just to follow up, Greg, on your point, I do not think we're going to be able to solve sort of the whole system today. The key components to this group and what our goals are, I think, is just to identify indicators to get the ball rolling, because APS is not getting the call or nursing home neglect and abuse is continuing and there has been no report and no response.

So, if we can get to the point of reporting, then we'll get to the system, also. I think it is imperative that when you make the call, that there is a response and we will talk about multidisciplinary teams and the appropriateness of that. But I think it is critical, at least from the law-enforcement side, that we at least hear about these cases, that we get a chance to take a look and try to find a remedy, whether it be a civil or a criminal remedy, to some very difficult problems.

So, with that, we will take a 15 minute break. We will reconvene at 10:30, 10-minute break.

[Recess at 10:19 a.m.]

DR. MOSQUEDA: We would like to go ahead and get started with the second session so that we try and give these discussions their full time available. One housekeeping issue in case you have not yet discovered it, because some of you do look a little bit stressed, is the restrooms are upstairs. I know where the women's room is, but I do not know where the men's room is. Not the same place, but close to each other.

MS. HEISLER: Same neighborhood.

DR. MOSQUEDA: Close to each other.

MR. HOFFMAN: We want to pick up with the second session talking about the application of forensic science and working with law-enforcement. And I think we will probably be revisiting some issues from the first session while go through this discussion. But we wanted to start with Candy Heisler, who has trained law-enforcement officials, has worked with medical personnel, has just been out there and we want to put her on the clock for the five minutes.

She will be familiar with the box, just to get us started.

Candy?

MS. HEISLER: I'm going to talk really fast, because if you have been around lawyers and some of you are us, you know that five minutes is not very much time. I've got a huge topic to talk about, but let me just start by saying we cannot do criminal prosecution or investigation of elder abuse and neglect without cooperation and collaboration with the medical side. It simply cannot be done.

So, what do I mean by that? I think there are two distinct areas where we rely on medical expertise. The first has to do with cognitive functioning, and by that I'm talking about how is this person, whether it is our victim or our suspect, able to communicate and what is their level of functioning

and legal competency, both today, when they may be going to court and in the past, when an event which may be an issue occurred.

The first issue within that discussion is first, is this person, victim or witness legally competent to testify? By that, I mean do they understand their duty to tell the truth, to understand the oath, do they have the ability to distinguish truth from fantasy and are they able to communicate information?

The second is the victim able to give consent, and this, of course, becomes particularly important when we're looking at sexual assault and the issue of consent. It becomes a little more complicated because typically, by the time a matter arrives in a courtroom, a number of months have occurred. And while a victim may appear hugely demented today or in some degree of confusion, the question is often when the incident occurred, six months ago, five months ago, a year ago, what was their level of functioning in the past?

There is a sub-issue of that, and that is how did this person present to the suspect at the time that the alleged consent occurred? Could the suspect reasonably believe this person understood and was able to give legal consent? And then, an issue that bears on credibility today in the courtroom, is this victim or witness legally going to be reliable, someone that is going to be a credible witness in front of a jury?

We also need to consider the suspect, because one of the evolving areas that we have to deal with is what do we do with the elderly suspect or defendant who is charged with a crime such as a homicide and now contends they have a disease, such as Alzheimer's, which prevents them and in the past prevented them from forming specific intent. We need the help of the mental health professional, the medical profession, to help us determine if this person, in fact, could form criminal intent. If they cannot, we may be looking at a different sort of response from the criminal justice system.

We are also dealing with present competency in the courtroom proceeding with our suspect. Does this person currently have the ability to understand the charges against them and to cooperate with counsel? So, that is a run through sort of the cognitive area. Let me turn now to the other area, which is diagnosis and identification of injuries and our reliance on you for really three functions.

They are: First, the recognition of elder abuse, and much of what we were talking about in the first hour are some of the issues that we have to deal with you; the documentation of what you see and learn; and then finally, reporting as provided for by your particular state law.

Among the areas that are clustered under this broad category are the following: What are we looking at; what is this; is it an injury or is this some sort of result of either aging or a disease process that has nothing to do with an injury inflicted by someone else? The second part of that is this an intentional injury or is it the result of an accident, and by that I mean is there something about the location, appearance or type of injury that you have identified that tells us that this, in fact, is medical injury resulting from infliction of an assault by someone else, or is this something that is an accidental injury that someone fell or bruised?

How long, to the extent possible — how long did it take this particular decubitus ulcer to get to the Stage IV it is today and what sorts of information would the care provider have had in the way of appearance, smell, or medical need that would tell us this person should have realized we had a person who required medical attention and that they were suffering from neglect?

With that injury, with the decubitus ulcer, do we have any indications that this person received care for their injury and was it adequate care and is the injury the results, the proximate cause of death

or did this person not die from the severe beating that they received, but rather died from the cancer that was growing in their bodies?

Finally, to what degree of medical certainty do you have this opinion and will you state it in a courtroom? And then finally, help us anticipate what the other side will do. What attacks would you anticipate would be made to the opinion you're going to render in a courtroom and are those attacks that we can defend against and overcome?

MR. HOFFMAN: Okay. Thanks, Candy. I want to open it with Bill Gambrell, and based on your experiences, Bill, in prosecuting some of these difficult cases, what your experience has been and your expectation from the medical community?

DR. GAMBRELL: Well, my experience has been that I have never had presented to me any of these obvious cases that we seem to be talking about here today. I told someone if anybody has any slam dunks, please send them my way. I would appreciate it. I think there are a myriad of issues that are involved in these things. My interaction with the medical community has been most of the time excellent, sometimes not so good.

Randy Thomas and I were talking ahead of time, too. There are two things that prosecutors and law enforcement people look for. They are sort of investigative opinions, you know, the early on, should we be looking at this? Are we heading in the right direction? Is this something we should be devoting time and energy to? And then the more important testimonial opinion, in other words, can I go to court with respect to this case?

I can tell you I have never been to a case where I have not had a doctor on the other side basically say, "No, that did not happen that way and no, there are 10,000 other logical explanations for the bruises that start from the forehead and go down to the shins." That is the nature of the beast in these matters, as we know, but that is just a reality, which is why it is so crucial early on to have competent medical advice in these matters.

South Carolina, luckily, is a small enough state geographically that we can get to the medical university in Charleston and get to the medical school in Columbia, and so we can usually find individuals to speak to. But I have had, I think, the typical problems, that there is a general reluctance on the part of doctors to get involved in these matters.

There is typically, in most of my cases, it is not a whodunit as much as it is a who didn't do it, frankly, in other words, instances of neglect in matters such as that where there are oftentimes doctors in the chain of authority, candidly, about it and everybody is pointing the finger at everyone else. "Well, the nurse should've caught that and when the nurse didn't catch it, it wasn't the doctor's fault because he didn't catch it."

And so, my experience has just generally been frustrating in that end. My last quick observation about that is, however, I think prosecutors too often cherry-pick these cases, I guess is my phrase. I've been doing this five years. We have had a Medicaid Fraud Control Unit for five years. We have got a 100-percent conviction rate on all of our abuse cases, and there have been 60 or 70 of them in that period of time.

That tells me obviously we're not pushing the envelope as we should do in the sense that we are catching people who are the obvious people who are doing these things, and the obvious people oftentimes are not the people who are doing the most harm in the long run. I think the people further up the system in facilities, directors of nursing, administrators, the doctors who are responsible for overseeing the care of the individuals in the facilities, have a significant liability in

these matters, but too often it is easy to focus on the lower-level individuals, which we, as prosecutors, I think do.

But I do think that sort of having an expert step up to the plate, so to speak, to help you is probably our biggest problem, and in that collaborative protection that everyone feels when a community of professionals is in the target zone, so to speak, is a significant factor.

MR. HOFFMAN: Okay, Bill. Randy Thomas?

MR. THOMAS: I want to just capitalize on what Bill said. I tend to look at this as a law enforcement investigator. First, in the first session, we talked about triggers and that brings up an interesting point. Until law enforcement becomes involved, somebody has to tell us. It is a reporting kind of thing. We rely on the fact that if you called us, you think something suspicious is involved, otherwise there would be no reason for us to be there.

That creates two problems for us. First is access to the medical community. It is all well and good to talk about large areas with a great deal of sophistication where you can find it, but a large part of the United States and a large number of law enforcement agencies serve very small, very rural populations where just finding an emergency room physician that understands trauma is a rare exception, let alone something as sophisticated as this.

The second thing, and I've had this happen to me as a child abuse investigator, as well as elder abuse, finding a medical person that will render a non-attributable opinion. Give me something to go by. I learned over time doing child abuse kind of how to do that myself in many cases. This is a far more complicated area, I think, medically.

I'm not going to put you up on the stand, but give me sense of direction. I always say in training the quickest way to clear out a hospital emergency room is wave a subpoena for a physician and they will all disappear. It is part joking and part very true. It is very hard to pin somebody down. Even finding that, I need to be able to come back to that system as I develop my case.

Understand that detectives very often do not work this area exclusively, and so therefore they may be homicide today. They may have done robbery yesterday. So, they are not going to have that base of expertise. I think over the years we have developed that for child abuse where we do have trained child abuse investigators, but as the departments get smaller, the less likely that is going to occur. And these cases don't just happen in big cities.

As a matter of fact, right now in South Carolina, a large portion of our caseload is in our small counties where we actually, as Bill says, we can get anywhere in two-and-a-half hours, so we can send the expertise to them, but that they may not hold true. My concerns are primarily looking at the challenges. Once it does get reported to us, we make the assumptions somebody found a trigger, but it has to be clearly articulated to us as to what you think happened here.

DR. MOSQUEDA: I have a question for the physicians in the audience, and that is, pardon me, not for the people who see living patients — have you ever had a police officer call and ask you to review something and give an opinion as to whether or not you think there may have been abuse? And, if so, is that common or rare for you to get that kind of a call?

Carmel Dyer?

DR. DYER: Yes, our team has received several calls. We work together with the APS in Harris County and we're known for doing elder work there. The key thing was that there was good documentation,

our records and from the reports we gave — we didn't really get called in. If the physician can document things well, the police have the evidence.

The biggest problem, though, with working with the police is that they do not often take the case any further because the patient themselves lacks the capacity to participate in the proceedings and, in fact, the lack of capacity really turns into a lack of advocacy for them, and so the cases are often dropped.

MR. HOFFMAN: Candy Heisler?

MS. HEISLER: If we look at the lessons learned in domestic violence, if we look at the lessons learned from child abuse, we've become quite proficient in learning how to build cases that don't rest on the shoulders of the victim, and we know that there are some cases, if the evidence is collected from the ground up, if there's a good preliminary and follow-up investigation and all of the pieces are put together from the beginning with the goal of going forward without a prosecution by the victim, then we can, in many cases, go forward.

The problem is we have not really, across the country, applied that approach to elder abuse. And it is going to take a certain amount of retooling our thinking and a little bit of experience and a whole lot of training, both for law enforcement and prosecutors. We will get there, but it is going to take us some time to do the foundational work.

MR. HOFFMAN: Dr. Hauda?

DR. HAUDA: Just echoing some of those comments, one of the biggest issues, I think, at least being a physician who is commonly asked by law enforcement, because I work with law enforcement on a regular basis as a medical examiner, is getting that call early, too. Obviously, we have talked already about an hour how do you identify the cases; the second issue often is we're better at this in child abuse than we are in elder abuse, is getting the cases really early, so that not only do you have the family practitioner who is seeing the person, the emergency room physician who is seeing the person, both of which do not want to go to court, you have someone who does want to go to court or is willing to go to court and testify to what they see, and if we can see that early, it makes a big difference, because then it's my eyes and ears that have talked with the person or seen it, not just I reviewed some medical records and this is what I found.

The second piece of that is we can often help the investigators plan their approach, as we have sort of already mentioned. We do that with child abuse. If the emergency department said this is a suspicious factor, we document this, that and the other thing, if you get a forensic physician involved, they can get the bone series done; they can get the pediatrician's records; they can start building some that information so when the case goes forward, you have got as much information as you could possibly have.

Obviously, that takes law enforcement or Adult Protective Services sort of taking the initiative to identify physicians that are willing to review these cases, willing to look at the patient, and can get paid for it, which is obviously something we have not talked about yet, but it is obviously one of the big issues. Most emergency physicians don't want to go to court.

Most family practitioner don't want to go to court, because they earn more money working than they are going to earn going to court. So, it is not in their interest really to testify for that patient, even though it's obviously in the patient's interest. But providing mechanisms, and there are lots of different mechanisms across the country, for paying physicians to be that expert, I think, is important.

In Virginia, my main role here is as one of those physicians who is working towards that end. There is actually legislation enacted two years ago for the physical abuse of kids, paralleled the same programs that were started a number of years ago, that now has this past year gone into any victim of any crime, you can have the commonwealth attorney pay a physician to evaluate that person.

So, Virginia has sort of taken this step forward. All of us are a little concerned — how do we apply that as physicians? Who is the physician that evaluates the person, what facility do you need? Obviously, as we have already mentioned in elder abuse what do you look at? What's the information that a forensic physician should garner and put together for the case, because obviously these are sometimes very difficult cases to put together.

And I think for a lot of people in the country, that is going to be the main focus, is trying to identify those physicians who are your experts and getting them paid for their services so that can continue to provide that service in lieu of whatever their other occupation is.

DR. MOSQUEDA: Are there enough experts?

MR. THOMAS: No.

MR. HOFFMAN: Law enforcement is saying no. What does the medical community believe? Any thoughts? Any clue? Well, we will take no, then, as the answer.

MR. THOMAS: Well, let me maybe qualify that, just two points. For one thing, our state does not have medical examiners. We have, I think, what, three forensic pathologists in the entire state? That is a problem. We are not alone or unique in that. The second thing is when you talk about identifying experts, there may be a lot of experts out there.

The truth is, law enforcement does not know who they are. We do in child abuse. We have learned that over time, but right now, we do not, and they may be there. I'm not saying they are not, but there is no handy-dandy list that you can reach for at 11 o'clock at night in somebody's home when you need to talk to somebody, nor do we have that many level-one trauma centers that you can even talk about trauma centers.

MR. HOFFMAN: I thought I saw another hand.

DR. LINDBLOOM: Talking to my own pathologist at the University of Missouri, I asked him about who we have in our own state who are interested and experts in forensic pathology and elder abuse and neglect, and he paused and said, "Well, I guess that would be me."

He sounded reluctant to take responsibility for that. He said that his own interest stemmed from the fact that he found that, in the rest of the state, there was not that level of interest there and took it upon himself to teach himself about some warning signs and other factors.

So I would definitely echo everyone else's opinion that there are not enough experts out there.

MR. HOFFMAN: Bill Gambrell?

DR. GAMBRELL: A point I wanted to make too related to it is incumbent upon law enforcement and prosecutors really to develop multidisciplinary teams, and I think that is the key, because one of the things we can do — because the medical expertise, the time is so valuable — is one of the things we have tried to do is to find doctors who would participate in educating part of the team so that it isn't as necessary as often to go badger a physician if there is a nurse assigned to the team, if there is a

social worker assigned to the team, an APS worker who has been educated who can oftentimes help the street cop and actually have that case turned over from the street cop to the team is the idea, but to have them provide guidance so that it doesn't always have to rise to the level of a physician.

But that is an absolute necessity when it comes time to go to the courtroom. I say that, I actually have prosecuted cases without doctors as experts just because I couldn't get a doctor as an expert in that particular case and have had to rely on another level of medical expertise.

MR. HOFFMAN: Okay.

Dr. Wolf?

DR. WOLF: I think the situation is really indicative of the fact that we really don't have enough geriatric physicians to begin with. So, what you're asking for is even a more-specialized kind of practitioner. We may have to look elsewhere; that is, do more training of other primary care physicians in this field.

MR. HOFFMAN: I think that's a great point.

Sue Ren?

MS. REN: I just wanted to comment that in Pennsylvania, approximately two years ago, the attorney general's office appointed a board that is comprised of prosecutors, detectives, people from Protective Services, nurse practitioners and geriatricians from all over the state.

The purpose of the board is to review cases that come into the attorney general's office, and where there is a discussion much like what we're were talking about right now, about what evidence do we have, how do we proceed, what kind of experts do we need, and also let me say there is also representation from the Department of Health there. We can talk about what are the expectations of care and institutionalized elderly, personal care homes and nursing homes.

And how that board has been productive has been to tease out some of these cases to really determine do we have anything here, first of all. And there has often been disagreement about that among the professionals there, but secondly then, if we're going to proceed, what else do we need to look for? What records do we need to get from the facilities? Who do we need to interview? Who do we charge and what do we charge them with, and who do we need as experts?

Do we need a physician? How about a nurse practitioner, someone from the Department of Health, et cetera? And that board is voluntary, our involvement in that is voluntary. However, if experts are needed, we're paid for our services, nurse practitioners and physicians are paid a fee for the time spent in record review and if they have to go to court.

MR. HOFFMAN: Before we get into a discussion of sort of multidisciplinary teams, I just want to sum up. At least it has been my experience, and I think what we have heard from other law enforcement officials, are basically we need causation, we need medical expertise to say what caused this harm, whether it be a death, whether it be malnutrition, dehydration, development of pressure ulcers, the treatment that was associated with that, whether they were preventable.

We will always hear from defendants or potential defendants that this was unavoidable and that is really the hurdle that we have to overcome, that these things were avoidable, that these medical conditions were not inevitable. That is what we will hear in virtually all cases. But we will also hear the defense that if things were so bad, at least for people who have been hospitalized on multiple

locations — if things were so bad, why would the hospital send somebody back, and if it really was poor care, why weren't the medical professionals who we are treating and seeing, why would they endanger somebody and put someone back into that environments?

And that is again raising the issue, going back again — I hate to go back — but from our first panel in talking about what do we do next after you have these suspicions to move this thing along so that there is involvement by professionals to take a look at whether there is abuse and neglect.

And that plays out in the legal world, as well, because it becomes a defense: If it was really that bad, these medical professionals would not have sent them back. I mean, they would not do that deliberately.

And that is why I just want to raise that with you in terms of getting to what you do next when you have these suspicions.

Dr. Peake?

DR. PEAKE: Well, healthcare only pays for acute treatment and this is a long-term issue. I mean, you come in, the acute condition is there. If that can be addressed — but then the follow-up, what kind of follow-up will there be in terms of the systems or the places where people are going to go back to?

DR. MOSQUEDA: Dr. Eisdorfer?

DR. EISDORFER: In direct answer to your question, it is reminiscent of that joke, and I don't mean to make light of this situation, about why the chronic gambler went to the gambling casino believing that the wheel was rigged. His comment was it was the only wheel in town.

We have a resource problem of really considerable substance. I would like Theresa to comment on this. Where do you send people? If you have abuse in the home, which is rare — and to answer another question, I have gotten several cases, both from the state and federal justice system. In every instance of a referral, it has been a nursing home.

The one case of abuse we have picked up in the home, we picked up as part of a project that I was doing. So, that is one issue. But where are the resources to be able to send people, and let me take another second. In the case of, for example, family abuse or abuse against women, one of the things we have learned is that if the abuse is taking place in the home, then you need to find secret safe-houses for women, because to accuse the abuser very often means the abuse will escalate from physical violence to murder.

What do we do with an older, frail, dependent, often demented person who is abused in either a nursing home, which by the way doesn't really like these kinds of patients because they don't make a lot of money on this group, or in the home itself? So, one of the issues, by answering the question, is we need a safety net for these people, and that will explain why we send them back. I wouldn't know where else to send them than back where they came from.

DR. MOSQUEDA: Lisa Nerenberg?

MS. NERENBERG: Well, actually, I wanted to comment on something, to just go back a couple of people. In the area of finding forensic specialists who can testify in elder abuse cases, I recently got an e-mail from a police officer who was a specialist in forensics entomology, who had been called

into a case to analyze maggots in a neglect situation involving an older person. And he went into great detail about what they do, which I will not go into.

But it got me curious about what forensic folks do, what different areas of expertise there are. So, I got online and was looking through one of the forensic association membership categories, and there were just thousands and thousands of people around the country, specialists in dentistry and orthopedics. It just occurred to me that Rosalie talked about trying to train geriatricians in doing forensics work.

I think the flip side of that is finding all these people that are already skilled in testifying in forensics issues and teaching them about elder abuse. I think a lot of that expertise is already there, if they understood our issue.

DR. MOSQUEDA: And, I think that works after somebody is dead. But, I mean, in terms of training the forensic experts in geriatrics, at least my understanding is that mostly you get involved later on. But, you're right. I think in an ongoing case, maybe we need to involve more forensic experts.

I just want to get us back to the issue that David brought up, and I think one reason we're not getting a good answer is because it is an answer we do not like. And the question is what do we do when we suspect abuse and what should we do when we suspect abuse in the office setting, but maybe before it gets to the forensic expert? The other thing to keep in mind, at least, I think, from a clinician's perspective, is we do not want to go after all these people and put them in jail.

There are different types of perpetrators, and I do not know if we will get into that much today, but the answer for everybody, as was mentioned in the opening remarks, is not always prosecution and putting them in jail. Although we're focusing on the forensic aspects today, I think we need to keep in mind that there are going to be different avenues to go through when we're looking at the perpetrators of abuse, also.

So, what should we be doing when we suspect abuse and what do we need in order to do it?

MR. HOFFMAN: Dr. Burgess?

MS. BURGESS: I would like to speak to that, plus one other thing that you just brought up. But on what to do, we can use the models that already exist for child protection and domestic violence. There has to be a safe place, if it is determined that there is abuse, that the go to.

One of the things we have heard even in nursing homes, and I can't believe this also doesn't happen in private homes, is that the elder will not want anything said because they are going to — they will get more abuse, if you will, from whoever, from the attendant or whoever is perpetrating the abuse. So, it has to be very carefully orchestrated.

So, that speaks to what I've heard, the theme that there needs to be a model a system or a system in place that people have to be able to follow to keep the elder safe. So, I like your idea perhaps there needs to be a shelter perhaps specifically for elders, that might be something that is taken up by the women's groups or something.

The second point I wanted to make that I hope at some point today we will talk about the perpetrator, because I think that does help in making the case, in putting it together; that we need to see what are the various motivations for who is perpetrating the abuse and to be able to counter that from however the defense is going to be able to portray it.

I would absolutely agree. Every single abuse or even sexual assault situation I have seen, there always has been an explanation, even if the person has been observed — there is an eyewitness to it.

MR. HOFFMAN: Okay.

Rosalie Wolf and then JoAnn?

DR. WOLF: There is the beginning of a network of shelters for elders across the country, just a beginning. However, they have great difficulties in terms of funding. Secondly, some elders do not want to be separated from the perpetrator. This represents their only companion, maybe someone they've been married to 50 years or more, and they would rather be there than in a nursing home or separated.

So, these are much more challenging, I think, cases than of the younger woman.

MR. HOFFMAN: And we want to move on to sort of the approach of multidisciplinary teams, because there is some concern that a case is reported and how it is pursued, there is a critical role for working together to really get at the issue. That includes a big medical component, and I think that is an area that some people are involved in, and we would like to hear, in terms of a potential model for going forward.

So, JoAnn?

MS. OTTO: Well, I would like to second what Rosalie said, in terms of there are some shelters available. Many victims do not want to leave home. Sixty percent or more of the abusers are family members. One of the things we have encountered with local multidisciplinary teams, which kind of follows on what other people have said, is that physicians and health-care professionals often cannot attend those teams because it is money out of their pocket to even go to a local team and do a review at the local level.

DR. MOSQUEDA: Wendy Wright?

DR. WRIGHT: Just real quickly, it speaks, I think, to both multidisciplinary teams in collaborating together and also remembering your role. Most states have mandated reporting laws, and if you recognize a case of abuse and you are a physician, you are a mandated reporter. So, it is not my job as a physician to decide the outcome of my report. That is why there is an investigatory process and why there are multidisciplinary teams.

It gets back to speaking about what David said about when you have a dead person that was in the hospital seven or eight times, why wasn't that reported? If everyone, especially from a medical perspective, says, "But I don't want them to leave their home. I don't want the perpetrator to go to jail. I'm not going to report," first of all, you're breaking the law. Second of all, you have perhaps not availed services that are open to that person by not making the report.

So, I want everyone, I think, in the health-care field to remember that as a mandated reporter, it is the law. You have to do it and you shouldn't decide by yourself the outcome of that case. That is the purpose of multidisciplinary teams, and if you have a multidisciplinary team, you can make the report and maybe nothing will come of the report. That's great.

Then the second time you make it, the third time you make it, the fourth time you make it, pretty soon you're building a case that then something is needs to be done and perhaps there are more services that can be offered, but if we in the health-care field say, "Well, I like the perpetrator.

It's just a case that they are overwhelmed, so I am not going to report," well, first, you know, you broke the law, and second of all, perhaps there were services, not necessarily homes for the person to go to, but in homes services, intensive preservation services that were available that they did not get to avail themselves of.

MR. HOFFMAN: To follow up, criminal and civil prosecution is not the end result and I guess we should disabuse people of the notion that somebody is going to jail in every case. That is just not happening or us we would not have this discussion, because I think there would be a huge deterrent effect, but we're not putting people in jail for this.

So, I would just keep that open, and when we're talking about law enforcement, I want to again mention there are civil remedies, as well as criminal remedies. There is consumer protection. There is injunctive relief. There are ways to force people to not act in a fashion that jeopardizes people, especially in an institutional setting.

So, I don't want us to just be focused on jail time, because that has a certain problem associated with it.

Jean?

MS. CONNOLLY: David, I wanted to follow up on your point and the point that Dr. Wright made, and that is I understand the concern that people don't want to report because they don't want something bad to happen to their care giver or they don't want to get themselves in even worse trouble. As you point out, despite those concerns; it is the legal responsibility of someone who is required under law to report.

But, that said, I think it is also important, as you indicated, that we think about how do we deal with the older victim and, in some cases, the care giver/perpetrator, where the hard-line prosecution is not the answer. As David indicated obviously we have a few more keys on the piano to play, but it seems that the multidisciplinary approach is the preferred approach.

So, my question to the group is what does the multidisciplinary team do? For example, you still need to do the reporting, but tell us more about what the multidisciplinary team does, both with respect to the older victim and the care giver.

MR. HOFFMAN: Carmel?

DR. DYER: Yes. The geriatric assessment team, although expensive, is really the ideal way to approach it, because they address everything that Candy talked about and what everyone else is talking about. They assess cognition routinely. These teams make these diagnoses in elderly people. They recognize and they learn how to document it.

This is under the purview of geriatricians, just like child abuse is in the purview of pediatricians. Now, the other thing is geriatric teams are used to assessing what elderly people die of. What is natural, what is not? We take care of these people all the time and we follow them in long-term care. Now, in Houston, with no additional dollars, we formed a team by linking the existing geriatric assessment team at the public hospital with the already-existing APS and it didn't take a time.

Now we are a resource for the law enforcement in that region and we are starting to spread out throughout the State of Texas. The one other thing we do, is try to prevent guardianships. Out of 100 cases last year, only five went to guardianship and only two were initiated by our team. The other three were brought to us from the guardianship program at APS.

We try to treat the underlying medical diagnoses and we monitor those patients through house calls. So, we go and we see what happens. And so, even if we do not take action right there, we can see if there are ongoing problems and hopefully prevent them.

MR. HOFFMAN: Okay.

Dr. Lachs?

DR. LACHS: Just a clinical observation is the incredible heterogeneity of this entity. I mean, elder abuse is a patient with Alzheimer's disease who becomes assaultive as part of his syndrome. It is a care giver who becomes briefly assaultive as part of care giving. This is a schizophrenic child beating up on an aging parent. It is spousal assault that is simply age.

So, what does a geriatric assessment or a multidisciplinary team do? They tailor interventions. I mean, the alcoholic kid needs something different than the care giver who is stressed out. These community partnerships that Carmel is describing where geriatrician's, APS, community service organizations that are well-acquainted with the kinds of resources in each community that need to be implemented, I think really is the key to sort of addressing this.

This is not a single diagnostic entity. This is an incredibly heterogeneous entity ranging from egregious assault and violence that we all would agree upon to stressed care givers, and to criminalize it is quite worrisome to me in every case, and it echoes the comments you made earlier, David.

MR. HOFFMAN: Catherine Hawes?

DR. HAWES: I want to say something about what I think you should add to multidisciplinary teams if the person is in a residential long-term care setting, a nursing home or a personal care home, and it was because I was struck by what Bill said about you can prosecute the certified nursing assistant and you can win, but you don't get the medical director or the director of nursing, and you didn't even mention the owner of the nursing home or the personal care home who may have created an environment in which the abuse and the neglect was inevitable, either by the way they structure resources or the way they structure incentives.

And I think it is important to have on the team someone who knows how to read cost reports, who understands financial accounting, who can look for the structures that make it occur in an institutional setting, not just the individual perpetrator.

MR. HOFFMAN: Okay.

Carrie Burnight?

DR. BURNIGHT: I think there is a variation in how familiar people are with multidisciplinary teams, and I think sometimes it is an easy term to throw around. What we need is a multidisciplinary team, and I thought it might be useful to take a second to really think through who are the members of the interdisciplinary team, because there may not be agreement in that of who needs to be on there, also some discussion of what the team does.

Dr. Lachs mentioned one thing we do is we tailor intervention to the very heterogeneous cases that we see. I am from California, and we have implemented a multidisciplinary elder abuse response team, and our funding came from the Archstone Foundation, a foundation in California, that enabled us to get going for three-year projects. We were lucky to have that foundation's support and not everybody does.

We're hoping that we can use this as one model, and Dr. Dyer, certainly we've built upon the model she has. Some of the players that we think are key, of course, a medical doctor, a psychologist — and a psychologist has been important in addressing capacity and undue influence and some of the financial issues that was just alluded to.

A social worker is very important in their interaction with Adult Protective Services, who are primarily social workers. Adult Protective Services has been extremely key to be on the team, because the reports are going through Adult Protective Services and come to us that way — a gerontologist, a little self-plug, and that is important in my opinion because, to keep track of the data so we can evaluate the effectiveness of what we're doing. So, not only are we doing, but we're really taking a step back and saying what works, what doesn't work in something that's new.

It's important to partner closely with the law enforcement, the police and the sheriff, with the district attorney and also the private legal community. In terms of what we do, it's getting the cases in, deciding what is and is not appropriate, and that is a big step, because there are many calls that are not necessarily — they can be handled in just an e-mail or just a telephone conversation.

So, to keep track of that — but they're not necessarily going through the whole team — then having a forum to sit down together with a group of players on a regular basis. We started more generally and had get more specific, that we meet every single week and go over every case, because sometimes just by being in the same room with all the players, you know, "Did that get there? Did that get connected?" The names of people and really knowing the players involved and sitting down with them and then proper documentation and then making sure that we're doing a follow up, because a lot of times we do our medical piece, it moves on and we didn't know what happened subsequently — so, instituting follow-up calls to say what happened in that case?

Many of the things are not as — I don't have a light, but if had one, it would be coming on — cases are not necessarily always so sinister that it is not sending somebody to jail, but it is getting some social services to help the care giver understand that it is not appropriate to be medicating somebody in that way just because they need to go to work or whatever it is.

So, there are the sinister cases, but there are also some where the perpetrator just needs some help.

MR. HOFFMAN: Dr. Pillemer?

DR. PILLEMER: I think this is a really important issue, and I think one way maybe I can speak to it is with Rosalie and Lisa, maybe having down one of the only at least quasi-scientifically conducted evaluations of several model projects, one of which was a multidisciplinary team project.

To me, I mean, it is just a no-brainer. At least, from a research perspective, the problem is what the sociologist would call simply an overdetermined problem. I mean, any case has so many causes and, an Mark has pointed out, the cases are so typically heterogeneous and so hard to pin down that I'm not even sure if assessment and intervention can even take place, if it is not in a multidisciplinary context.

Let me just say one or two quick reasons for that. The one thing which is important to remember and we have not really touched on it is that the incidence of serious elder abuse and especially of physical elder abuse is relatively low compared to other family violence problems. So, it is not a high base rate phenomenon, and the signs and symptoms often can be caused by benign factors.

So really, even more than we said, the chances of false positives are really enormous, and I think a multidisciplinary team is critical in order to avoid those, because the consequences are so devastating. Second of all is I think we have effectively established clear forensic signs of elder abuse or physical signs that would lead you invariably to a conclusion that elder abuse has occurred are so rare, are extremely rare occurrences, and that's what the team does, too.

But I think the third thing is an issue which has already been touched on. I just want to touch on it again, is that the importance of context is so critical that it can only be accurately assessed by a multidisciplinary team. I mean, I have seen in expert testimony work signs and symptoms which could clearly be attributed to something else, but that are leapt on by surveyors as signs of abuse even when the context of the nursing home would argue against it.

The final thing I would say is that these teams — I mean, but we do have different categories of certainty. So, we have a case of a clear pattern of injuries that couldn't be explained any other way and maybe it doesn't need a team or maybe it's a fairly straightforward event. However, it goes all the way down to a dysphagic, combative nursing resident who suffers from mild malnutrition. I just don't think it's possible for a single individual professional to accurately assess it.

So, if you couple that with the evaluation data that exist, it is just — I mean, that this particular entity really seems to work.

MR. HOFFMAN: Randy Thomas?

MR. THOMAS: I would just very quickly like to give what I think is a law enforcement perspective on, as Carl says, a no-brainer issue, whether or not we should have an MDT, and this comes from my experience both in participating in child and elder MDTs, first is access to expertise. As a police officer, as a detective, I need to talk to people who have expertise I do not have.

Second and corollary to that is the more I do that, the better educated I become and the better educated they become on how I work. The third thing is that personal contacts and relationships can never be underestimated. It is that ability to call somebody you know, that you deal with, and talk realistically about what you are. That brings up this barrier issue. There are legal barriers, issues with confidentiality.

A lot of times, the MOAs for MDT's get past all that. It becomes now a protecting-your-turf kind of issue. It more becomes a question of how big do you want the MDT? How sophisticated is it going to be? We tend-ours tend to work in a small state better with intake issues than they do long-term stuff. But I've seen variations on a theme.

MR. HOFFMAN: Okay, Patti McFeeley?

DR. McFEELEY: Well, I think speaking also to the multidisciplinary team approach, and I tend to jump right in and say, well, but unless they die, the forensic pathologist is not involved. I think forensics can be very much involved, and using the model of child abuse, I mean, most forensic pathologists examine live children. Many of them go to the hospital and participate. There are many that actually specialize in examining children, for instance, for the kind of pattern injuries and the kind of things that Dr. Hood described in his brief paper, that sometimes a forensic pathologist can

identify better, as far as patterns or obvious ideas of abuse that may not be as clear to someone who does general medicine, for instance.

But, in addition, the other aspects of forensic can be very much utilized. She was talking about the entomologist being involved. That is not really that far out. The odontologist — we had an odontologist coming in and deciding whether that really is a bite mark and does that bite mark actually match with someone else. The DNA people, if you're talking about multiple rapes or sexual assaults in an institution, it may be not only identifying a perpetrator, but it may be identifying that strain of STD is the same and that so that is, in fact, by the same person or passed around the same area.

Those forensic experts should be part of that team or at least have entree to that team that you can utilize, because I think they can really add a lot to the investigation or to deciding whether you really have an abuse instance.

MR. HOFFMAN: Just a follow-up with that, because I think it is a critical point and I think it would provide great evidence, but are forensic pathologists getting involved and is there a willingness, because I can't even get them in actual death cases, and I live in a big city where it is being done, but the surrounding counties where counting coroners are unwilling to autopsy older people, especially out of the facility. There is an unwillingness to move forward and sort of be cooperative in that fashion.

You don't have attendings ordering autopsies because they also are the medical director, and it sort of becomes a self-reporting problem potentially as to their position. I mean, how do we sort of move that forward as part of the multidisciplinary response? Do you think including pathologists on this kind of team would get them on board with that or what is the approach?

Dr. Hood?

DR. HOOD: Well, Patricia and I, Patti McFeeley and I, have both been involved in that kind of thing. We have both sat on multidisciplinary teams and you're getting the same message. We do have our part to play. Frequently, your forensic pathologists are your best witnesses because they do it all the time. And they have also seen the very worst end of the spectrum, so they are in much better position to say that this was a non-self-inflicted and deliberately inflicted by another pattern of wounding.

It is a lot easier for people like us to get up and swear on a stack of Bibles and say that very confidently within a reasonable medical certainty than a family practitioner or a gerontologist may be able to do, because most of the time they're not looking at those kinds of injuries. Even though they may see a case, be appalled by it, dutifully report it, when it comes down to talking to the law-enforcement people, you discover they don't handle themselves well under cross-examination because you were taught, as a scientist going through medical school, to accept that there are many possible ways by which a thing could happen.

Frequently, if they're asked on the stand by the defense, "Well, couldn't it be or is it possible that," the answer is yes, and it frustrates the hell out of the prosecutor who has just prepped the individual, not realizing they were going to answer that way, because they don't understand the implications of that; whereas I might be inclined to answer and say, "Well, anything is possible," and then wait and let the prosecutor intervene, object appropriately, just simply because they don't understand what's going on in the court and how evidence is presented, and because they have an academic training.

It took most of us as forensic pathologists five years of training to get out of that mode of thinking. So, it does help to have people like your forensic pathologists on the team, but they are by no means the be-all and end-all of getting a good case put together or not even getting a good case together, but just getting a good result.

As I have already said, a good result doesn't necessarily mean that somebody gets prosecuted. In fact, that may not help at all. It may just simply remove one abusive nursing aide and have them replaced with another low-cost version of the same thing in the same nursing home. I have certainly seen that. I would reiterate what you have heard already, that you want a team that is not too big and unwieldy, and particularly of people who can themselves fan out and bring in, if need be, a whole bunch of experts that you might otherwise have regarded as rather abstruse, like the forensic entomologist, the maggot person and that kind of thing.

There's no point having them sit on the multidisciplinary team up front, but you need somebody on the team that knows about them and can bring them in, and you should have a core team of about half-a-dozen people.

DR. MOSQUEDA: Right. So, let's just address that issue a minute with this group of experts. If there is general agreement, which it seems there is, that a multidisciplinary team would be useful — well, let me ask. Is there general agreement on that? Is there anybody who disagrees with that? Who dare say so?

Then who should be the members of the core team who always need to be at the table, and if we can do this sort of quickly without big explanations as to why, but just to throw it out.

Carl Eisdorfer?

DR. EISDORFER: That is clear, it depends. For example, in the memory disorder clinics that exist in the State of Florida and going back, actually the project we created in Seattle 20 years ago or more, we always included a neurologist and a psychiatrist. And, in Seattle, we actually included an architect around the issue of falls and problems in the home that might have to be changed.

In the VA project that we are running now, it is a combined geriatric medicine/geriatric psychiatry project, and I want to add something about that. The latest data we have coming out of that combination of a multidisciplinary team, maybe ultimately it saves money, because the early detection of depression and cognitive disability changes the nature of the medical and often surgical care.

So, it may not be more expensive. Indeed, it may be less expensive.

DR. MOSQUEDA: But let's get to the issues. I'm sorry to interrupt. For a multidisciplinary team, for elder abuse.

DR. EISDORFER: My problem is you want one, two, three, four, five, and people don't come packaged like that, at least I haven't seen any. So, the issue is what is it you are trying to establish? If you're trying to establish the cause of a suicide, you need one group of people. If you're trying to look at the cause of a depression, you need another group of people. If you want a general medical approach, then you need a geriatrician, for sure, plus other screening people, plus a second tier of people who can become the experts.

MR. HOFFMAN: I think there should be a core component, at least in working with law-enforcement, a core component, then you can sort of expand out depending on what the case-specific needs are. But as a core component, for those who have multidisciplinary teams, who needs to be on it?

Carmel?

DR. DYER: Doctor, nurse, social worker — those are already well-established, the traditional team members of interdisciplinary teams, and an APS specialist. Absolutely.

MR. HOFFMAN: And Randy? And law enforcement.

DR. PAVEZA: I would argue you need both the law-enforcement officer and you need an attorney who specializes — and a prosecutor, actually, would be the best option.

MR. HOFFMAN: Rosalie?

DR. WOLF: I know we were not going to talk about financial exploitation. It to be a big problem, so you really need somebody on that team who represents financial planning and the whole financial picture.

MR. HOFFMAN: Well, but I sense where we are headed. By the time we get around our table, here is our multidisciplinary team.

DR. WOLF: I also want to say that there are a few states that require a multidisciplinary team, and it is up to the supervisor of APS when that team gets together. And you may be interested that in Illinois, they include on their team a clergyman.

MR. HOFFMAN: Okay.

Lisa?

MS. NERENBERG: There are a lot of different models of multidisciplinary teams and they are used for different purposes, ranging from an Adult Protective Service unit that has a team that includes a nurse and a cop to go out on certain cases where it seems like their expertise is going to be needed right at the beginning in making the initial assessment. On the other end of the spectrum are groups like the fiduciary abuse specialist teams in Los Angeles that has, I believe, like 50 people.

So, clearly, what the intent of the team is going to influence — you know, what is discussed and how it is discussed. These large teams, for the most part, are not pulled together to discuss individual cases, although often they do, but another secondary purposes is to create expertise within the group. I would like to say that Rosalie brought up financial abuse, and that seems like it is a little bit far afield from the discussions here, but I don't believe it is.

The team in Los Angeles was one of the first groups that started to bring up this connection between neglect and physical abuse and with financial motive. So, the more people you bring in, the more people are going to start making these kinds of connections. And I want to make one other quick point, and that is just that one of them, I think, roles of the teams has been to create expertise, forensic expertise, in a community.

I think our community really turned a corner at one point when we had Candy Heisler come to one of our meetings and talk about a case that we had been involved with that she was trying to prosecute. Sitting down with all group of social service and medical and all kinds of people and

telling us what she had to prove — these are the elements of a crime; these are the standards that I need to reach — got people thinking very differently.

They became partners in a process, whereas in the past, I think people felt like they were kind of the victims of the criminal justice system. So, I think it advanced the knowledge base.

DR. MOSQUEDA: I think we might need to just define sort of the role of the team, as I think we're talking about it in this context, which is really to be able to look at potential abuse cases and help figure out whether or not we think abuse may have occurred. So, it is a slightly different concept. I serve on both the Los Angeles and Orange County fiduciary abuse teams, and they do, they get huge. But they have much more purpose than just identifying whether or not there was abuse.

It has to get to — we educate each other very much and part of the reason the team is so huge is because everybody wants to learn more about it, and we have a lot of involvement, but it still begs the question of can this group say there is a core group of disciplines that need to be involved when you want to figure out whether or not there has been abuse.

And what I'm getting at is this is a little bit different concept than maybe what already exists or a little bit of a twist on what already exists.

MR. HOFFMAN: Bill Gambrell?

DR. GAMBRELL: Well, the quick answer to that question is doctor, APS, social worker, cop, attorney, nurse, for that particular one. Now, obviously everybody has made the point, and it is extremely well-taken, that you cannot use a multidisciplinary team without putting it in context, also. In other words, what is that team supposed to attack?

The second thing I wanted to point out is reporting equals money. One of the problems for establishing multidisciplinary teams and assisting in funding is helping people. The reason you can't get funding is because of the vast under reporting, because every time you go and talk to someone about we want to put a team together, this is a tremendous problem, we pull out these wonderful anecdotal stories, but when some legislator, appropriately, or some governmental official says show me your stats for these instances of elder abuse, I start talking about tearjerking cases because I've got no stats to pull out, and I think that is an important component of a multidisciplinary team, which goes to the reporting issue.

MR. HOFFMAN: I think what I'm hearing is when you say physician, and after I heard from Patti and Ian, I think there are two kinds of physicians we're talking about. We're talking about a geriatrician, and we're also talking about a forensic pathologist, which, I think, has not been historically sort of thought about in terms of bringing them to the table while you're dealing with a live body, which may be of some value to people throughout the country to know that would be an approach and have some value when we're talking about forensic evidence.

Dr. Peake?

DR. PEAKE: Well, maybe it is a kind of a stage issue, too, because we talk about having what would be the bare-bones team, which is really important, and then we talk too about people who stick their neck out and go into this and feel like, "Well, I'm kind of lost." So, the collateral members of such a team could be like a secondary kind of a thing that you have access to, and then you're cutting down, from a financial standpoint, what we need bare-bones and then who are the others, so that there is more of a network for support; or, as I hear so much of people going out and thinking, "Do I

really want to report this? It's going to take me hours and hours," and those kinds of things. So, the acute and then this kind of secondary resource.

MR. HOFFMAN: Joann Otto?

MS. OTTO: Well, I think we're looking at location, and in a rural area of Colorado, we're not going to have a geriatrician. However, it would be helpful in addition to having a local team to have experts at the state level and maybe the national level that we could call on to help those folks in Bent County, for instance.

MS. CONNOLLY: Following up on that point, I think one of the issues that might be interesting to discuss is the formation of forensic centers, potentially at the national level because we have so few experts in this area — that could be accessed either by e-mail or by telemedicine. Another alternative are the regional forensic centers that Dr. Hauda has taught us about. And I know Laura has talked about an even more localized type of forensic center be a mobile unit doing house calls. I'm interested in your thoughts about what type of a forensic center or concentrated forensic center might be most effective to start with. Given where we are at this point, what would be the best resource?

DR. LACHS: I think that is a potentially good idea. I mean, the good news is that geriatricians, the team, is the procedure of geriatrics. We are very comfortable with that for other geriatric syndromes, and I consider elder abuse to be a geriatric syndrome, you know, for falling, you know, mobility, we'll have a physical therapist with an occupational therapist, with a nurse and a social worker and a physician. That is the good news. The bad news is good luck finding one.

I think there is a critical shortage — Rosalie made this point earlier — there's a critical shortage of geriatricians in the United States. And in rural areas, you're going to have to rely on some sort of forensic center infrastructure that we might discuss here.

DR. MOSQUEDA: What are your thoughts?

DR. LACHS: Well, you know, certainly at the state level or the regional level, it might be worthwhile to have these more concentrated areas of expertise, epi teams, if you will, to help to adjudicate these cases that come up from smaller jurisdictions.

MR. HOFFMAN: Dr. Lindbloom?

DR. LINDBLOOM: I think it is also important as we talk about tiers on this team, and about resources in rural areas, clergy was mentioned. Some sort of community leader or clergy that can help understand some of the issues of cultural diversity and that sort of thing when these cases come up.

Now, I'm not struck with a whole lot of cultural diversity at this table, for example. An I have found that bringing in some community leaders in our team rally helps us understand some of the issues that patients and family members might be facing at home.

MR. HOFFMAN: Okay. Dr. Eisdorfer?

DR. EISDORFER: I think the direction we're going in is really great, because I don't think we need to talk exclusively about teams. I think we need to talk about panels, and I think we really need a panel of experts, very much like if you have a basketball team, whether you win or lose may depend more upon the bench rather than the five people who are on the field.

So, I think what we probably need, apropos of a forensic center, is to begin to train a diversity of people who have a variety of expertise and who can be drawn upon on as-needed basis, given the specifics that are involved.

MR. HOFFMAN: Dr. Sanders, and I think we're going to be moving into education shortly.

DR. SANDERS: Also, telemedicine is the wave of the future. The team doesn't have to be sitting in the same room in a rural city in Colorado. You can have local people that make home visits and then report to an expert like Dr. Dyer or Dr. Lachs or other people. So, there's room for creativity. I think a geriatrician, though, needs to be somehow involved in making the decision.

MR. HOFFMAN: Okay. I think that is a great point.

MS. CONNOLLY: I think it might be worth trying to state where we have consensus coming out of this. It seems there's broad consensus that we don't have enough experts in the area, that we don't have enough geriatricians and, that we need to establish clear forensic signs of elder abuse in order to create screening tools and to move this forward.

We need to look at the issue of who pays doctors, the emergency room folks and the primary care physicians who take on this issue. We need to include more forensic pathologists on our teams in order to bring in that expertise, not only with the dead, but also with the living. And, as Dr. Wright pointed out, we need to move where our assumptions.

It appears that pediatricians have a quite different than geriatricians of how to interpret reporting requirements. What I'm hearing is that while pediatricians may view reporting requirements them as a necessary evil or inevitability - they report. Whereas physicians who treat older patients are less likely to report suspected abuse or neglect. It appears that in the child abuse area, it has been helpful to have pediatric forensic experts who actually do the reporting, with whom other physicians can consult. From what I've heard here, it sounds like geriatric forensic experts might provide a helpful bridge - or buffer - between the frontline care providers and the agency receiving reports of suspected abuse and neglect.

MR. HOFFMAN: Okay. Catharine, you're objecting to that summary?

DR. HAWES: I just think there's one thing

I would like to add to it, and that is the discussion we heard about the need for resources to help resolve problems, either places that patients can be discharged from hospitals that are safer than the places they came from or interventions for potential abusers or actual abusers in the way that we have in adult foster care and Child Protective Services, sort of a range of interventions.

We haven't really talked about the other resolutions very much.

MR. HOFFMAN: Okay. I think we need to get to our next one on education and I think these are things that we again want to address, but perhaps are not going to get to today. In terms of the education, we have Greg leading us off, Greg Paveza. Greg, are you on the clock? Did we lose our operator?

DR. PAVEZA: We lost our operator.

MR. HOFFMAN: Time is up, Greg. Thank you.

[Laughter.]

MR. HOFFMAN: Thank you for your brief remarks. That worked out well. Carmel, would you like to follow up to that? DR. PAVEZA: I can do one of two things. If we can't get it going —

DR. MOSQUEDA: Go ahead.

DR. PAVEZA: Let me begin by saying that whatever I say here are my personal opinions. That is my disclaimer, given the fact that I sit on another group that is charged with looking at this whole issue of education, of health professionals around family violence. So, I want folks to know that these are my personal opinions and not the opinions of that group.

But, with that said, what I want folks to begin to think about is, in essence, that age-old question expanded a bit, which is who needs to know what and when do they need to know it? We have to acknowledge that the purpose of basic education in the healthcare professions and, indeed, in all of the professions sitting around this table, whether it is law, medicine, social work, nursing, that basic education is to turn out practitioners that we feel comfortable with letting loose on the world.

It is not to turn out specialists. That goes on in most of the professions sitting around this table in advanced post-professional education. However, when we start at that basic level, one of the issues that is of critical importance to me is the fact that at that basic level, we expand basic training in aging. There is not a profession sitting around this table in which we would all agree that there is sufficient education around aging in the core training of our professionals.

It does not happen in medicine. It does not happen in nursing. It does not happen in social work. It does not happen in law. So, we need to expand basic geriatric education. As an example, several years ago at a meeting I went through a gob of textbooks, literally hundreds of textbooks on human development. All of them had five chapters on child development, seven chapters on adult development and a half-chapter on old age and development of the elder adult.

We need to make sure that our professionals then at a basic level know about geriatrics and know about aging and what is the normal aging process. Once we get beyond that, we need to begin to address post-basic education, residency programs, the first several years of practice in which specialties begin to develop. I believe it is at that level where we need to begin to make sure that the variety of professionals who are likely to come in contact with older adults begin to receive basic education and training around issues that allow them to begin to identify adults who are being abused and neglected.

Now, that takes us back to what do we teach them, given the lack of solid indicators? And I think what we need to do is have the training that goes on in professional education teach folks how to begin to put together context, which is the other issue that folks have addressed around this table consistently. What does a pattern begin to look like that should lead you to suspect that abuse and neglect is occurring?

And then, what are the actions that you need to take, to go back to Dr. Wright's point, even if you don't particularly like one of the courses of action that is dictated, which is reporting this to the appropriate body, whether it is law enforcement or Adult Protective Services.

And so, we need to begin to teach them that this is a context in which you can begin to identify people who are being abused. The last area that needs to be addressed from my perspective is this whole issue of continuing medical education and continuing education. When we began to look at continuing medical education and continuing education, one of the interesting things that we

discover, and this is true across the board, is much of that education is, if you will excuse me, a cover-your-ass approach; that is, what do you need to do to make sure you don't get prosecuted for failure to report, as opposed to how do you identify or how do you begin to put together the context of education.

What I would like to then suggest is that continuing education needs to take a different format, which is specifically targeted again to training people in the context of identification and the overall indicators that may be used to point you in a direction. With that, I will give it to whoever is next.

MR. HOFFMAN: Carmel Dyer?

DR. DYER: Well, I can answer the question about education and elder abuse by raising three. The first is how can we establish or prove the value of education and elder mistreatment? How can we convince the academic centers then of this value? Third, once we teach the learners about it, what will we teach them to do? And I can answer those three questions with two phrases, and they are, one, increase research, two, change policy.

Now, how do we prove the value of elder mistreatment? Well, we need to have it as Candy and David wrote in their statements, and Mark, we need elder deaths to be noteworthy. We need to prosecute the APs. Do you ever read in the newspaper, how somebody who was actively neglecting an elder is prosecuted? Doctors are not reading that in the newspaper. It is not important.

The other thing is to train the experts like we talked about with interdisciplinary team or setting up forensic centers. But what if we said to every medical school that has state funds, what if we said, "You please designate an elder abuse expert at your medical school facility? Wouldn't that raise the level of importance? Wouldn't that put that up on the radar screen for them?"

Secondly is how do we convince the academic centers once we prove the value? One way might be in how we utilize the Medicare dollars. Now, Medicare is the medical program for older people and we are training obstetricians on those dollars. And, with the changing demographics, - are there any incentives in Medicare for the medical schools to train more geriatrics? No.

We need to convince physicians and nurses that this is not just a social problem. Some of my colleagues think elder abuse is really just a social issue, there is no medical relevance. So, we have to disavow them of that. The other thing is to realize that a topic becomes part of the medical school curriculum depends on whose is a part of the school leadership.

Are there any geriatricians on the curriculum committee? Do they have a position of importance at the medical school? And you know how get that, through grants and papers, which are the currency of medical schools. So, we have to show them the currency.

Lastly, what will the learners do once we teach them all this great stuff and how to recognize it?

Well, first of all, we could give them the didactics and the basic sciences, but if there are not role models at the bedside, they are not going to learn it. I can learn about congestive heart failure from a piece of paper, but if when I get to the bedside, either the professor gives that case in an older person short shrift or does not point out the physical exam signs of the heart failure, it is not going to stick with me and I'm not going to think it is important.

The other thing we all talk about in geriatrics how great it is to work on the team. We hold hands and we have team-building conferences and everything, but are there good outcome studies on

interdisciplinary team approaches that we can show other physicians and say, "Look, here are the outcomes," and the cost-effective implications?

And so, I guess, to achieve the three goals that I talked about — that is, to prove the value, convince the academic centers and to give the learners something to do, we have to approach elder mistreatment education by, increased research and changed policy.

DR. MOSQUEDA: What do you really think about this?

Dr. Burgess?

MS. BURGESS: There is one other place to try to influence that something gets into a curriculum and that is to make sure on state board examinations there are questions that are going to be asked on that. And that is what we have done in nursing, that state boards will ask in the area of violence. So, this would just be another suggestion.

DR. MOSQUEDA: I think that's an excellent point. There's nothing to motivate a school to teach a topic than knowing that it will help their students pass the exams and make them look good, and that is a very real issue that we ought to work toward. I also just want to, particularly because I'm also representing the American Geriatric Society, is say that I don't think we can abdicate our responsibility and just say there aren't enough geriatrics.

For the geriatricians there are, very few of us have expertise in elder abuse, and really all of us ought to, and we ought to push our own society to do more education in the area of elder abuse, also.

MR. HOFFMAN: Let's talk a little bit about the law enforcement side, in terms of educating law enforcement, because you may do the best assessment. You may go to a police officer or investigator and have wonderful ideas and this was neglect or abuse, and they look at you like you still have two heads.

Why do we get the law enforcement crowd, in terms of education? What do they need to do and how do we institutionalize that?

Randy?

MR. THOMAS: I can explain specifically what we do in our state. It's part of our basic law enforcement curriculum. At least, it is more an awareness thing in going through our state statute, our adult protection statute. I understand very often that is probably not the place to teach your police officers. They get a lot of information and it gets screened out very quickly when they get out there.

It is an integral part, interestingly enough, of our two-week child abuse investigator course. We devote a lot of time now with elder abuse, primarily because these are the folks that probably will get these cases as much as they do that. And Bill can talk to this probably as well as I can. We have spent, what, the last six years in the State of South Carolina doing multidisciplinary training. We actually have a multidisciplinary training handbook that applies to all state agencies.

It involves law enforcement, APS. We're on the road a lot. We have actually brought in folks from the national level twice now through our U.S. Attorney's office, using some of their training money. You just have to actively go after it. Now, having said that, it is not as difficult a sell to police officers as you might imagine.

In all my experience in training police officers, I have never failed to have at least two officers in my class that have not had to deal with elder abuse as a personal issue. And it really isn't easy to sink the hook, in terms of not only do you need to pay attention professionally, but there are issues that we're going to talk about that could affect you personally, either that or one of your family members.

That's the only class I teach where I can make that statement and actually get away with it. I think we've made a lot of efforts. Candy and I will tell you we've gone a lot of places in the last couple of years training police officers. But, the downside, we're on a high turnover right now in law enforcement. Our state is turning over about 20, 25 percent of our police officers every year.

Agencies can't get them. Even major law enforcement agencies cannot fill the vacancies they have. It is a sign of a good economy, folks. It is not a process you can quit doing. You just consistently have to go after it and just make it an institutionalized and integrated part of your program.

MR. HOFFMAN: Well, as part of the training, and then we will go to Candy on prosecutors and perhaps other law enforcement personnel, what is that they need to hear? It is from soup-to-nuts, investigating how to deal with an older victim, the different approaches to an older victim and the special needs of an older victim?

What does the training include? And then, when we get to the prosecutor, again there are similar things in dealing with an older victim, but also a proof issue.

MR. THOMAS: It has to have a legal component, because for us to be involved, there has to be at least the indication of a criminal involvement. So, we do a little bit of that, who is covered. Our statute basically is vulnerable adult. We go through the indicators. As you well know, they are very complex, very difficult sometimes. But, interestingly enough, in training police officers — those of you who have done it, you'll know this — I have a lot of pictures. They like that.

But I will tell you, most of my police officers know what a gunshot wound is. They do not know what a pressure sore looks like, and when you start showing them pictures, they start to have a frame of reference. That may be the most important thing, is just that cognitive framework that says, "Okay, this may or may not be abuse."

Interviewing, dealing with somebody, most of my police officers are in their mid-20s, which is making me feel older by the day. That is a population group they have a difficult time relating to. That population group has a difficult time dealing with the police officer. You know, send me back a real adult is sometime the comment that you hear.

You say that it should not interfere. It truly does. So, yeah, it is sort of a broad-spectrum approach. A lot of it is, truthfully, awareness. Who do you call when you do see something that may indicate abuse?

MR. HOFFMAN: Would it be of value, and then I will turn it over to Candy — would it be of value to have a geriatrician go out to law enforcement as part of the training? It's one thing to show pictures, but it is another to have a medical expert get up and say, or somebody who has been used as expert witness in a criminal trial, get up and say this is why we concluded neglect, from a law-enforcement perspective?

MR. THOMAS: Absolutely. I think most police officers want training. They want sophisticated training. I have never heard anybody tell me they didn't. They can tolerate a high level of sophistication, as long as it is done at layman's terms. The physician whose teaches our child abuse

spends nine hours with our child abuse investigators and she, in fact, goes through it in terms that they can understand. That is not denigrating their ability. It has just got to be in terms they understand.

It's not a difficult thing to do. It is finding them somebody that is willing to do it. And I think you're right, we need to have — somebody needs to teach them about the process of aging. As I said, you're talking folks in their mid-20s. The need to know how this works; that not everybody who is 85 is impaired, and a lot of my officers think they are.

MR. HOFFMAN: Candy Heisler?

MS. HEISLER: Let me just add to some of Randy's comments around law-enforcement and then spend a moment talking about prosecutors in different ways. With law enforcement, what we in California and in many other states have found works best is it is relatively easy to get law-enforcement trained, but what you do is you pass a law.

In our state, for example, it has been relatively easy over the last three sessions of our legislature where elder abuse has suddenly become the currency of the real and the feeding frenzy has really begun to get mandated training. Now, yes, that carries a dollar sign with it, but our state has put its dollar signs in front of elder abuse, as opposed to whatever the other crime of the week is.

So, as of now, we are developing new training. We're doing it in two different areas for law enforcement. The one is just basic information and that includes the topics that Randy highlighted, in addition, reporting responsibilities and also seam preservation and evidence collection, which, of course, translates into prosecutable cases where a crime can be shown and a perpetrator can be identified.

We also are looking at more advanced training because of a bill that authorizes law enforcement to seize assets where a public guardian is going to pursue a conservatorship. But, in order for law enforcement to be able to do that, it is specialized to officers who have received fairly-advanced training in this particular area of recognition, as well as investigation.

And where they have a basis for concluding, and guardianship in our state is called a conservatorship, where a conservatorship would be appropriate. So, this is driving the desire for enhanced training, very advanced training for law enforcement. I would go a little further and say there are our some differing ways we go about educating law enforcement.

Everyone thinks of our urban centers, but we have some very distant places within a state that is over 1,000 miles long. We have some areas that are as remote and as rural as any of yours, and we need to get training out there, too. Indeed, in some cases, that is the place where training is the most critical.

So, using the State Commission on Peace Officer Standards and Training, which we euphemistically called POST, using POST as the repository for setting up this training, they have gone to a variety of formats consisting of telecourses or distance learning classes which have the advantage of bringing experts to a film site, allowing these experts, folks like our two California doctors here, to go on camera, talk about medical aspects, talk about what they can bring to the table and educate many officers where we do not have the ability to take them to each and every community, to the 500-some agencies around our state and actually do face-to-face sit-downs.

So, through telecourses, we bring other prosecutors in, we bring law-enforcement in to explain to them how do you do these cases. We have also developed, as part of other training courses, in

particular an investigations course for law enforcement, a five-day course on domestic violence, a whole component part on domestic violence in later life. This gives us a chance to do much more refined training and to talk more specialized about abuse and neglect cases.

Turning quickly from the law-enforcement training overview to training prosecutors, we simply have to do it and we need to understand that it is not mandated in any state I know of for prosecutors to receive training, period. They do not have to receive training about this subject in law school and they certainly do not have to have it for professional development in a prosecutor's office.

Many are choosing to get it, particularly when they are getting assigned or facing assignment to specialized units. Increasingly, we are seeing the development of specialized elder abuse units, so that the need for this and the desire to learn it is increasing. The California DA's Association has taught a freestanding seminar for multidisciplinary members, not just prosecutors, on elder abuse for the last 10-plus years.

It has now grown to a multi-day from a half-day format years ago to something between three-and four-days long, offered on an annual basis. Other states are doing the same. Other states, as well as our own, are, through their prosecutor's association annual training days, are bringing in people to train broadly on the subject of elder abuse.

So, we are finally starting to see the first little inklings and move forward. I'm very glad to see the National DA's Association, for example, is present here and looking on, because I think they are key players in making this happen more broadly. And then finally, the National College of District Attorneys, which annually provides many different training courses as part of its domestic violence seminar, has now added elder domestic violence and elder abuse to the training.

And the people doing that, I do part of that training, but I'm joined by a medical expert who is a forensic pathologist from Indianapolis, who is very expert in elder abuse, and so we're getting that multidisciplinary team modeled and also that valuable expertise. So, there's a quick overview.

MR. HOFFMAN: Great. Thanks, Candy. Dr. Eisdorfer, I think I saw your hand up or was I seeing things?

DR. EISDORFER: Just to comment. In our case in Florida, where we do have support from the state, our group has a team consisting of a psychologist and a geriatric nurse Ph.D. educator who had been around 25 percent of the police departments. They get subsidized by the state and have created, at the request of the state, a multimedia presentation. I suspect that is true of many of the states represented around here.

One of the things that would be helpful maybe is to aggregate these so we would have a library of multimedia presentations that people can really turn to. Another area that we have particular targeted just conceptually are judges. I think it is a very important issue of educating — you know, we're talking about the doctors and the lawyers. Most judges are lawyers, I think.

I think that is a different level that we really need to get to, because these are people who do make decisions that are critical to certainly all of the attorneys here. There's one area that I have been holding back, because I'm sort of venturing on thin ice, but I am in a different time zone, not having slept for a couple of nights, so I will press it.

A lot of what we are facing are often really instances of medical malpractice which trigger off abuse. Misuse of medications, withholding of visits, partly because of the economics of nursing home care,

pretty much mandate that a physician see a patient once a month, but often as not falls and so on are really not followed up. That creates an interesting problem.

And let me take another minute, as long as the light is not on. I think the primary reason that physicians do not like to deal with this issue has nothing to do with the money, in my experience. It's probably the same reason that lawyers don't like to go see doctors, because they don't want to find that they're ill. Doctors don't like to see lawyers because they have this vision of being cross-examined on the stand and getting involved and if you do this, you may have to hire your own lawyer to protect you.

So, I think we have an interesting problem, and I think you suggested something that is very important. Where does the report of a colleague, whether you're an attorney or a physician, make sense? Most of us dislike it, but I was looking for a successful model. I know of one very successful model of the reporting of colleagues, even though it is mandated. The one model I know is the so-called impaired physician.

Physicians around the table are aware of that. If you know of a colleague who has substance abuse, you can report that colleague and that colleague will get help rather than prosecutorial attention. So, one of the things that we might want to think about as a creative approach to the problem is can we identify an issue and try to be helpful at first, obviously, ultimately we may have to prosecute and can we intervene in some way that prevents further abuse, that may salvage the family or, in the case of a physician who is not acting appropriately in a nursing home or with patients, in general.

DR. MOSQUEDA: Great. And we're going to sort of steer back to the education topic, also here, please.

Erik Lindbloom?

DR. LINDBLOOM: Randy Thomas mentioned the high turnover rate in law-enforcement, and it is also important in a lot of different fields we're addressing here, such as Adult Protective Services and the nursing home. And residency training, by design, has 100-percent turnover over a three year period in internal medicine and family practice, for example.

I think we really need to think about, in education, training the trainers, getting people who are champions in their area that will be around to train future people locally in their departments. It is pretty impractical to expect someone like Randy to continue traveling all over the state, or all over the country, to do these presentations when we could be training people locally to do the same thing, to really take it under their wing as a cause at their medical school, at their agency, or their nursing home.

DR. MOSQUEDA: But I just want to also ask Lisa Nerenberg or Dr. Wolf to comment on this idea of a repository of information. I do not know if you have anything to say about that. I know that the national council has been asking for people to send in training materials. Is that right?

DR. WOLF: The National Center for Elder Abuse, which is here in Washington will be collecting training materials for all disciplines. I just want to say, from a national perspective, I think the law enforcement people are doing pretty well when you compare it to the medical personnel.

I mean, the most local APS units will try to set up training for their local police, but they have a hard time trying to get any physicians to come to training.

DR. MOSQUEDA: Good point. I think the other thing that we face, for instance, in our county is we have 26 different police departments. And with the high turnover, it just feels like you're lecturing to a parade sometimes, too.

MR. HOFFMAN: Joanne Otto? I just want to put on the record that I did not pay Rosalie to say that about law enforcement doing better than the medical community, since it is being transcribed.

MS. OTTO: I don't know personally of any graduate schools of social work that offer curricula in elder abuse, and that is a big gap, as far as I'm concerned. It goes back to what Carmel talks about, the research is where you get the money. There are a lot of issues that have been identified in the last few years, areas of much-needed research.

And certainly identifying that is a first step, but then there has to be funding to give those schools an incentive to get folks to do the research and to get the students in there who have an interest. So, that is one thing that I would like to stress. The other thing is that there is no standard of training for APS around the country.

Our national organization, NAPSA, has been working on trying to develop some standards because we don't have any kind of federal leadership in that particular area. So, we're working on that, and again, it is a resource issue.

MR. HOFFMAN: All right.

Dr. Hood?

DR. HOOD: On Randy's question of law enforcement and education, I think rather than concentrate on getting sophisticated training of already-graduated police officers who may be working in that area, we sometimes forget there is a need to start right at the beginning in the police academy.

It is just beginning to become a trend now to start to bring in other than veteran police training personnel, into the academy setting. I know in Philadelphia, the medical examiner's office, at least, does give a regularly recurring set of lectures and training to each academy graduating group or at least the group of cadets that will graduate.

I think it is very important that they start to consider having a geriatrician give some training in the advanced setting, right at the basic academy training level, not just because of elder abuse, but you have got to look upon the fact that about half of their complainants that they will deal with the day they hit the street are going to be elderly or at least will be very elderly as far as most of their 25-year-old minds are concerned.

DR. MOSQUEDA: That would be all of us.

DR. HOOD: In addition to that, a lot of their witnesses that they will be trying to interview, who may not even be complainants, are going to be elderly. A lot of them have no concept of the cognitive skills of elderly people and how they work, that they could, in fact, be good witnesses if they were aware of that.

I have certainly seen a 23-year-old, recently-promoted detective carry out a photo I.D. with an 85-year-old mugging victim in a way that was obviously not going to lead to a useful result just because of lack of knowledge of the kind of person they were dealing with. So, I do think, right at the academy level, you need some geriatric input.

DR. MOSQUEDA: I think one overarching theme, almost no matter what field, is sort of this pyramid approach, something Dr. Wright and I have used in designing training programs, which is who do you need to educate sort of at what level. I think Greg Paveza brought this up in some of his opening comments, which is if you look to a certain extent at the people who are geriatric experts, be they geriatric nurse practitioners, geriatricians, et cetera, that is a whole different level of expertise that you want to do training — in relation to training — than a medical student.

And I am wondering if we can talk about that for a moment. I think both in the medical field and in other fields, would you agree that there are different levels of training that we want as people sort of move up the pyramid, in terms of their level of expertise in geriatrics?

MR. HOFFMAN: We'll start with Catherine Hawes.

DR. HAWES: I think the answer is yes, but I think there are a couple of groups that we have left out. One is nurse surveyors and complaint investigators and state agencies who are charged, aside from APS, with investigating complaints in residential long-term care settings.

There is nothing worse for a case than having the health department find that the home is in compliance with all standards or to have an unsubstantiated complaint about abuse in a facility. And the rates vary from state-to-state, from two percent substantiation of complaints to 67 percent. So, I think there is some real importance in educating those people about good complaint investigations and involving them in these teams that you're talking about where the case involves a residential setting.

The second is — and it has to do with both the level of education that is needed and of funding — and that is the public health community. We have talked about how unresponsive hospitals are. Maybe we need to start educating the hospital administrators, the people in health policy and management who will run both local health departments who can raise community awareness of this and are the people who are running the outpatient clinics, the hospitals, the places where it might be seen, about what is needed to support the health-care professionals who could do both the detecting and the reporting.

The other is that somewhere in the 427 objectives of Healthy People 2010, there is bound to be one that applies to elder abuse.

That is a way to specifically define the issue and make every federal agency responsible for providing funding for the achievement of that objective. And I guess you could probably get APHA to adopt a resolution on this that would put it higher on the agenda of the federal funding agencies.

DR. SANDERS: I would like to reinforce what was said before about different levels and the estimate that we are not at that stage yet. It sounds to me like we aren't at that stage yet. One suggestion would be to have a consensus of who needs to know what at what level.

For example, even as an emergency room physician interested in this area, I'm not sure. It ranges from screen everyone to ask one question to look for high-risk criteria or a combination. Where on the pyramid do we go now and then plug into a system? So I'm not even sure what to teach my own residents and students.

So, one thing would be to develop a consensus, what does a geriatrician need to know? I'm actually surprised it is not in the curriculum and in the examination and other things, what does a primary care physician — you know, what does a paramedic need to know at various levels?

And then the second element would be developing strategic plans with people in the disciplines, and I have a lot of suggestions for emergency medicine in terms of the RRC and even JCAHCO has some rules about elder abuse protocols which I do not think are regularly followed. But there are ways to then implement what we want once we have defined that.

DR. MOSQUEDA: So, the idea of a consensus on who needs to know what at different levels is brought up.

Yes, Lisa Nerenberg?

MS. NERENBERG: I would like to take it out a step even farther, the idea of teaching health and social service providers, APS workers, some of the medical or health indicators they may need to know about. We're starting to work with law enforcement about basic indicators of capacity issues, and similarly I think that there are certain areas of health that they need to know about.

Now that I've brought up insects and people already think I'm a kook, I will talk about larger animals. There has been some interest by the humane organizations. Animal care and control folks have been reaching out to the human service, human protective services network, child and elder, adult abuse people, because they are starting to observe situations that they see in doing their own investigations.

They find situations of severe neglect that the human service investigators are missing. That idea was kind of interesting to me. I am wondering if there are some gross indicators of severe neglect that we should be training our APS people in.

MS. CONNOLLY: Another suggestion along those lines has grown out of the State Working Groups that we have tried to form at the state and local levels as part of our Nursing Home Initiative, and Dr. Hauda has participated in the Virginia group. We also had firefighters, ambulance, EMC and have been trying to reach out more to the first responders, because, by and large, they have no training in how to identify any signs of elder abuse or neglect. And they don't know what to do with what they see.

So, we have been working with frontline providers to get them some training in that regard, to help them develop some sort of a screening tool internally that would trigger reporting or referrals out, and also to try and help them establish some sort of internal protocols. This applies not only to fire departments, but broadly to all types of first-responder types of agencies.

DR. MOSQUEDA: So, it sounds like we all agree that pretty much everybody needs to be trained in the area of elder abuse.

MS. CONNOLLY: And we need more money.

DR. MOSQUEDA: And we need more money. We agree on that, and we like animals. And it sounds like there is some general agreement with this idea of sort of the pyramid, that we need to establish who needs to be trained at what different levels, and it would be nice if there was some consensus on this.

The interesting question for me is always at what level do you need consensus? We did it within our own state, then can you apply that nationally or will everybody disagree with what we've come up with in our expert course for geriatricians?

I think the other important question, though, has to do with — and that is within our own disciplines. One thing we haven't really touched on is cross-discipline training. That has been brought up a little bit, and I think, as physicians, we must admit that we are notoriously bad about going to multidisciplinary trainings; that we are much better about going to trainings if they really are for physicians.

I think that is clearly reflected in the multidisciplinary trainings that are done, and there usually is a real sorrow that more physicians didn't come, and I don't know if there is any way to address that.

Greg Paveza?

DR. PAVEZA: Laura, I think your point is well-taken. When I train interdisciplinary teams, we spend almost a day just on the issue of cross-training. Interdisciplinary teams require that you understand the language of the other person sitting around the table. You have to understand a social worker has to understand the language of an attorney, of a nurse, of a physician.

And we make the error of assuming that we know what everybody else is talking about, and when an attorney or a law enforcement officer says probable cause to me, I have to know what they're talking about. When I say the magic word in social work, empowerment, which everybody just cringed at, you still have to have some understanding of what I mean by that term.

We have to understand the values of those professions. It is easy to get social workers, law enforcement officers, interestingly enough, and nurses to come to interdisciplinary trainings. The hardest groups that I have getting to interdisciplinary trainings, and I think until there are questions or it is mandated as part of licensing renewal, and I am always reluctant to get into that little quagmire — but until it is mandated that if you are going to work in a particular area, you need interdisciplinary training and you're going to be faced with documenting that, people tend not to respond, but attorneys and physicians are the hardest to get.

MS. CONNOLLY: Has anyone had any success getting those types of folks to their training? What do you recommend?

DR. HOOD: I would recommend that you use the CLE and CME process, continuing legal education and continuing medical education that is a requirement for licensure or renewal of licensure in the most states. It is a nice carrot, and sometimes both the physicians and lawyers are looking for something out of the ordinary when they're going to do that, that is more than just the hum-drum stuff that they may be doing every day and reading the journals on every day, anyhow.

And that seems to be the most attractive. I know it is to me, anyway, and when I go to those kind of training sessions, I am surprised at the variety of professionals that are there, and I always learn a heck of a lot more at those than I do when I go to something that is in my own particular area.

I would far rather go to a CME day session that includes something like engineering for accident investigation, because that appeals to me, epidemiology and other things that would not normally be part of my everyday experience. So, I think that is a good place to start.

MS. CONNOLLY: Dr. Wolf?

DR. WOLF: One of the most successful that I did was a CME where they gave quality assurance credits. Those are required and difficult to obtain, and this brought out, in a relatively rural county, about 100 physicians; and that has probably been the best showing that I've ever had.

MS. CONNOLLY: Do the pediatricians have any recommendations in this area?

DR. WRIGHT: You would think that after having done — theoretically child abuse is fairly far ahead of elder abuse in terms of lots of things — training is not one of them. I think there are very few medical school curriculums that have child abuse taught in the basic curriculum.

In fact, going through medical school, I never heard of it. My own pediatric residency this very year now has a two-week mandated rotation for our pediatric residents in family violence. It started in July and it took about a year for us to do that. We just did it within our pediatric residency. When we developed the California training center for areas of all violence education that Dr. Mosqueda and I participated in, we have had people advocating at the University of California regents level, which mandates training in all of our University of California medical schools in order to get family violence on the curriculum of our seven California medical schools and have not yet been successful.

So, I think that what I have to say in terms of educating healthcare practitioners is not very good. On a personal level, I do agree that law enforcement has done a much better job and one place that I do think that we need to also look at is emergency medical technicians or EMT. There are a lot of first responders, and San Diego County has done a very good job.

In fact, every time the class goes through, I think I've given 15 different classes of paramedics the same lecture, and it is sort of monotonous after awhile, but when you feel like you're doing something, it gets you there to do it. But I've done much more training for law enforcement, EMT, physicians, district attorneys, child abuse detectives than I have within the realm of medical schools.

So, I think what I have to say in that arena is not very promising.

DR. MOSQUEDA: Mark Lachs?

DR. LACHS: I think if you want to get physicians interested in this issue, and some of my social science colleagues cringe at this, I think you need to medicalize this. I think the chronic disease model — physicians are in the mind set of pattern recognition that relates to differential diagnosis.

I think physicians respond to data. I have seen very little. I think the data, for example, that we saw earlier that suggests that this has as much sort of mortality associated with it as all the other chronic diseases that they typically treat.

When I lecture to physicians, I tell them that you might fill them with blood pressure medicine and raise it or lower it. Take someone out of an abusive environment. I mean, that's an improvement in quality of life. I also think, from a financial vantage, we need data that shows — and I believe this is true — that family violence victims of any age behave in the health system like people with chronic disease.

They are expensive. We know that older adults, for example, use emergency services at an alarming rate. I suspect they are misdiagnosed. There is tremendous misattribution. If you're in managed care plan, you know, and you come to the emergency department because you had an arrhythmia or because you were not fed, somebody's paying. I think those are the points that need to be made. We need data to support that.

MR. HOFFMAN: Let me throw out — it may not be real popular right before we go to lunch, sort of the legal model, since everyone is under mandatory reporting, sort of when you see prosecutors enforcing the law and you hear of physicians being prosecuted for failure to report, would that inspire people to learn more about it in terms of the — I mean, because this is a big issue.

There were physicians that were prosecuted in the child abuse arena for failing to report, and there is some value in that from a law enforcement perspective, to inspire others to sort of come forward.

Dr. Sanders?

DR. SANDERS: Just to respond to that, I think that is a poor method of changing behavior. For all the discussion that went on here, you would have to demonstrate that they knew abuse was going on and failed to report it when it is such a complicated issue with other than way on top of the pyramid.

I want to mention that there is a literature on changing physician behavior, and the trap is you put on a CME course and you think people visit or you send out a position statement from a professional society and you think people are doing it. That is why I think after the consensus, I really think you need a strategic planning conference, and it may be based — okay, now how do we get to paramedics? How do we get to geriatricians. That is, I think, much more effective; and there are mechanisms of doing it, some through regulation, some through feedback of physician leaders, various things like that. We're not going to solve it here, but I would recommend that as a plan of how do we implement these.

DR. MOSQUEDA: Great. I think we're going to start to wrap it up here. Part of what you're talking about might be related back to what Dr. Eisdorfer mentioned earlier, using that impaired physician model, which I think is an very intriguing idea and takes more of an educational approach.

I'm sorry we're going to cut off so that we can get to lunch. I know people have more to say on this topic, but I think this all leads us very well into the topic after lunch, which will be on research and what needs to be done in the area of research, because we've heard that as theme running throughout all of our earlier comments, I think.

[Whereupon, at 12:30 p.m., the discussion

recessed, to reconvene at 1:00 p.m. this same day.] AFTERNOON SESSION

[1:11 p.m.]

MS. VETA: We're about to start on our fourth session, which will focus on research. Julie Samuels, who is the Acting Director of our National Institute of Justice was hoping to be able to join us today, but unfortunately, she was out of the office yesterday because of illness and unfortunately cannot be with us here today, but we do have Lisa Foreman, who is one of our colleagues.

Lisa is the Acting Director of our Investigative and Forensic Science Division within NIJ, and, as you know, the Department of Justice is very interested in the research topics. And with that, I will turn it over to Laura and David to begin the fourth session.

DR. MOSQUEDA: Let's just launch right into it. Just to tell people a little bit about our time schedule here, we're going to go for about an hour talking about the research issues, and then we will spend about 15 minutes of wrap-up and have about a 20-to-30-minute break before the Attorney General comes.

MS. VETA: Right. And as part of that, you'll notice on your schedule, although the schedule shows the Attorney General coming at 2:30, there have been some intervening events, so hopefully she will be joining us at around three o'clock.

DR. MOSQUEDA: So, with that, I would like to introduce Dr. Sidney Stahl from the NIA to kick us off in the research topic.

DR. STAHL: Thank you for inviting me. I'm intrigued by what I've heard so far today, but also a little depressed by what I've heard so far today, in that there is so little science base behind the sorts of decisions that are and I would like to address that. I think that what I will end up doing is making a plea for some sort of a national research agenda, multiagency research agenda on elder abuse and neglect, based on the desperate need, I believe, for very targeted research in various kinds of areas.

I'm also delighted to announce that just this week, the director of an NAS panel was assigned, and that the NIA and the National Academy of Sciences will be doing an 18-month study on elder abuse and neglect to help create a national research agenda in that area. My own feeling is that without a rigorous scientific research in specific areas of elder abuse and neglect, solutions to the problem that you've been talking about all day are simply not going to happen.

If indeed solutions do happen, you will not know why they happened and you won't be able to repeat them in other kinds of settings. So, social service and law enforcement and the medical and health-care areas really need to have a very informed, specific research agenda. I realize that the people in the trenches in geriatric medicine, in social work and so forth and certainly in law enforcement need to respond quickly and they can't wait for a full-blown research agenda or all the results that may come out of it. But, indeed, in the long run, that is probably the only way that we're going to find out how to deal with this problem and make any kind of an inroad in that problem.

With that in mind, I've outlined what I consider to be seven areas of needed research. The first of the areas is that we know nothing about the prevalence and risk factors in elder abuse and neglect.

There's no nationally-based probabilistic study on elder abuse and neglect. The closest thing that we have, appropriately, is something that is about a dozen years old and that Karl Pillemer did in Boston, and the figure that we usually use in the literature basically comes from that, which is about five percent of the population.

So, one of the first things we need to do is to come up with a reasonable prevalence estimate of elder abuse and neglect in the United States, and that has implications for the risk factors that are associated with it that you've been talking about all day. If, indeed, the risk factors are subject to the biases inherent in each of the nonprobability surveys that you do, then we really won't know exactly what the risk factors are in elder abuse and neglect.

So, there is a very real need — the first topic is there is a very real need for a national probability survey on elder abuse and neglect to not only come up with the prevalence statement, but also to come up with what the risk factors are. There's also a lack of adequate measurement. That is something that all of you have talked about today, and I wonder if it's not possible to come up with a single metric that is useful and culturally sensitive across various disciplines, law enforcement disciplines, clinical medicine, clinical sciences and the social sciences.

The third area of need, I believe, is the need for some sort of a natural history of abuse and neglect. Like child abuse, we do not know, is elder abuse a learned response to stressors occurring within the family? Is frailty a precursor or a result, for example, of elder abuse and neglect? At any rate, the answers to those sorts of questions, I think, will dictate the kinds of interventions that we eventually can use in elder abuse and neglect.

The fourth area is one of a lack of diagnostic specificity. Again, we've heard a great deal about that. Mark Lachstalked about that. Several other people have talked about that today. We know that depression, for example, I think Dr. Eisdorfer talked about it, also, that depression is common for

the elderly, but it may also be an absolutely appropriate response to an abusive and neglectful situation.

So, we need research on diagnostic specificity regarding elder abuse and neglect. The fifth area is a lack of scientific verified preventive interventions. We talked about intervening, law enforcement intervening, but there are other ways to intervene if, indeed, there's a natural history within a family and there is a need to deal with the family, there must be other ways than disrupting the family dynamic by pulling the elderly individual out of there.

So, we need to have some scientifically-verified prevention and intervention studies. The National Academy of Sciences in its publication about two years ago, I guess now, on family violence found literally two studies, two studies in the thousands that they reviewed that met their criteria for scientific adequacy on abuse and neglect. That is surprising to me, especially given how much the behavioral and social sciences know about group therapy, about group dynamics and so forth, that we don't have a better handle on how to intervene in these situations.

The sixth area that I think desperately needs some sort of serious scientific research, and I know one we were told not to look into, the area of self-neglect. Certainly there must be alternatives to nursing home placement for self-neglect situations. Are there effective community services? Can we demonstrate efficacy in community services that can demonstrate both their social and economic cost-effectiveness in keeping self-neglective individuals out of the more restrictive nursing home environment?

The seventh area that I have identified is in terms of institutional abuse and neglect. There is depressingly little scientific information about this area. The President had a statement about it a week or two ago, I believe. Despite the general feeling that this is a significant problem, it's time, I think, to separate sensation from science on this and learn exactly what is going on in nursing homes, what are the characteristics of nursing home workers, what are the characteristics of the environment of the nursing home that lead to abuse and neglect?

Well, in this quick, I guess, seven minutes — somebody forgot to turn the little clock on, and I appreciate that I've tried to give you enough to chew on, at least for the next hour. One way or the other, I think that these problems are certainly not going to be solved overnight. They are too complex and too unknown. But there needs to be a concerted scientific effort the research community with tremendous input, both from the legal community and the social service community, in terms of what are the issues and how can we address those issues to solve this particular problem?

DR. MOSQUEDA: Thank you, Dr. Stahl. I will also just remind everybody that this is laid out in more detail in the paper that Dr. Stahl wrote and is in your notebooks, to all these points. Our first respondent is Dr. Wolf.

DR. WOLF: First of all, it is reassuring to learn from Sid Stahl that the National Institute on Aging and the National Academy of Sciences will be working on an agenda. I think that is great news, and I think from that we can expect some really great things to happen. I am reminded of a panel on this very subject that convened about 10 years ago, and at that time, they talked about prevalence studies, the validation and assessment of diagnostic tools and the evaluation of treatment and prevention programs as priority.

And those priorities, 10 years later, still exist. And, in spite of the intervening years, the knowledge base is still not mature enough to do any policy or program development, as you have heard. The information is lacking not only on the intrapersonal and interpersonal dynamics, contextual factors and societal factors that lead to abuse, but also about the consequences.

We know very little about the consequences, yet there are hundreds of Adult Protective Service workers, law enforcement, criminal justice personnel handling thousands of cases, but scant attention has been given to how effective their work is and the services that they obtain for clients. As part of a work plan for the National Center on Elder Abuse, we did a workshop with 50 Adult Protective Service workers — actually administrators — to find out what people in the field really need to know, and studies on intervention types, on effectiveness and program outcome measures seem to dominate the findings.

But they had a relatively large number of items related to criminal justice, such as the effectiveness of criminal statutes and its relationship to prosecution, how do criminal checks correlate with reducing risks of abuse, what are the effects of enhanced penalties, more prosecution and background checks for elder abuse incidents.

The need to learn more about the effectiveness of intervention really came through very clearly from the National Academy of Sciences study done a few years ago on the assessment of family violence interventions, which looked at all forms of family violence. While it was true they did not find very much for child abuse or for domestic violence, they found nothing on elder abuse.

And there were challenges. There are challenges in methodology. There are challenges on logistics and design that have to be resolved, but what also came out of that study was the need for collaborative partnerships between researchers and service providers. And a similar recommendation came from an earlier study that was on the research on violence against women.

In 1999, the CDC decided to fund a center whose mission would be to help prevent violence against women by advancing knowledge about prevention, research and fostering collaboration among advocates, practitioners, policymakers and researchers. So, this was an effort to respond to the findings of the need for collaboration, and a series of focus groups was held across the country.

While most practitioners had some experience with data collection, they spoke negatively about a degree of remoteness or even arrogance on the part of researchers, the insufficient attention of researchers to their effect on victims, the practitioner opinions neither solicited or respected, and then the inconvenience, from a practitioner's point of view, of participation.

So, they made some recommendations for researchers, and that was to respect the practitioner, to enhance mutual trust, to establish open communication, reduce negative experience and acknowledge fundamental differences between those trained and working as practitioners and those as researchers. So, that's the real mission of the center and what really came out of those two studies is that what we need to do is have a better collaboration.

DR. MOSQUEDA: Dr. Pillemer?

DR. PILLEMER: Well, I thought I had sort of obsessed about this issue enough that I'll just limit myself to two or three points, because I could actually talk about it until you had to pry this microphone from my lifeless fingers.

DR. MOSQUEDA: It's a good thing we have medical examiners here.

DR. PILLEMER: I mean, really I would like to be a little stronger than Sid or Rosalie and say that the gaps in the research base are just appalling, and whenever I come to a conference like this — and this is not a criticism of anyone's presentation or discussion — but I will note that after Mark Lach's initial remarks, I did not hear a single individual start his sentence with, "In a study I conducted,"

"As research shows," you know, like it might have happened. But at least I was not aware of anybody saying research demonstrates this.

You know, in a sense, a part of the goal of this conference, as I understand it, is to look at some of the scientific basis of the decisions we're making. That really gives one pause. I just want to say three things about research very briefly that I think are relevant, especially to this group. I mean, one of the most difficult things in the area has simply been that people have not become interested in this line of research.

So, with child abuse and wife abuse, you had well-established scholars, psychologists and sociologists and medical folks who got interested in it. For some reason, those of us in who do research in this area, as I have said before, kind of feel like we're in the Flat Earth Society, you know, that it is this small group of researchers and the actual names haven't changed very much in the last eight or 10 years.

So, their needs to be some way to inspire people to find it as an interesting topic of research. I think most relevant, though, to this group of legal and medical professionals, I think one of the barriers or one of the reasons why people haven't done it is because of a lack of easy access to victims and perpetrators. And lots of what we know about child abuse and the sexual abuse of children and abuse of women has come from interviewing victims and there even have been almost professionalized victims who work in this area and kind of help to facilitate the research.

Most researchers have found tremendous barriers in getting subjects, and I think that is a major reason that agencies feel like they have to protect the victims from researchers, and I know that Rosalie and I have run up against this and many other people have. The last thing I'll say is just in terms of evaluation of programs, again, in our last discussion about these training programs, I didn't hear a single reference to, "And we evaluated this program using a case control design and found that people who received this kind of education reported more or were more effective."

We cannot wrest funding for this line of research until people devote resources to systematic evaluation of programs conducted in a scientifically rigorous way. I mean, I will say it this strongly, there is almost no reason to continue having these kinds of conferences unless we can up the research base so we have something to base these kind of statements that we are making on.

So, I think like, in addition to research funding, we have to stop providing funding to intervention programs which don't involve a careful evaluation of what they do, including the kinds of training programs which have already been discussed. I think we have to take a very hard-line attitude on the need now to establish a scientific base for this work.

DR. MOSQUEDA: I'm assuming this will engender some comments.

Erik Lindbloom?

DR. LINDBLOOM: I think we all agree there is a huge need for generation of primary data, and to do that, we need a lot more researchers in this area. Right now, I'm directing our geriatric medicine fellowship, which we really set up to fill a niche for family doctors and internists particularly interested in academic geriatrics, research, education, et cetera.

Recently, the accreditation of geriatric fellowships went to a one-year-only set up. which has really made it difficult for a lot of these two-year or three-year curriculum. I can say that my phone is not ringing off the hook with people who want to do a two-year or three-year geriatric medicine fellowship with research built into it, hoping to become a so-called "big-R" Researcher.

When you look at primary-care doctors to begin with, depending on who you talk to, you're already dealing with a shortage of physicians who go into primary care, then you're taking that group and looking at primary-care physicians who want to do research, which is a much smaller group, and then geriatricians, which is a much smaller group, and then geriatric researchers who want to look at elder abuse and neglect, and you're dealing with a very small pool here.

So, I think one solution to that or one suggestion is something that we have already talked about, getting in relatively early in medical education and really turning people on to geriatrics and prevention of abuse and neglect as a major priority in medical education.

DR. MOSQUEDA: Is this an area where if, you provide the money, they will come?

DR. LINDBLOOM: Yes, I think that is part of it. I think that it—at least geriatrics, in general, and geriatric research in particular is not seen as a high priority on the national scene and on the medical school scene, as well. so I think yes, making it a higher priority in that way could help.

DR. MOSQUEDA: Joanne Otto?

MS. OTTO: Well, I just want to confirm what Karl said. As a person in the practice of Adult Protective Services for 20 years, I've been flying by the seat of my pants and really not knowing whether what I was trying to do was effective. When Mark Lachs put out his study, I wondered whether the cause for morbidity had to do with the abuse or the fact that an adult protection worker became involved in somebody's life, and that is not a trivial question for us in the practice.

DR. MOSQUEDA: Greg Paveza?

DR. PAVEZA: Well, first of all, I would probably suggest — and this goes back a little bit to Karl's remarks, I'm not sure that if we put money into it, they will come. I mean, I hate to say this, because I do the research in this area, but this is not the most attractive area in the world to want to get in and do research.

Most researchers have a great deal of difficulty looking at, I think, wanting to deal with people's pain and suffering and trying to figure out why. The second issue really has to do with collaborative funding of research, NIA, NIJ, National Center for Nursing Research need to be prepared to fund the level of research that needs to be done.

It goes to a point that we all know, but it has been said a couple of times. This is, in some respects, a rare-occurring phenomenon in terms of its — and we do not know that for a fact. It goes to Sid's point. We don't really know what the prevalence is. But if we continue to look at some that data that is out there, it is a relatively rare-occurring phenomenon. That means large sample sizes in order to be able to distinguish what are the markers for abuse and what aren't the markers.

We are talking about studies that are going to cost \$2.5 million or more over a three-year period, and nobody is prepared to fund that.

DR. MOSQUEDA: So, I mean, not only do we need large sample sizes, we need long lengths of time for follow-up, which also makes it additionally more expensive and more difficult to perform and fund. And another issue that we're encountering, and I'm interested in some discussion on this, is just IRB issues.

The very person — you have to have them sign an informed consent to participate in a study, and if you have somebody who has a dementia or some other impaired capacity, the very person you

might be asking for the informed consent for the multidisciplinary team intervention might be the abuser. I'm just wondering if anybody else has encountered that as a barrier for research.

DR. PAVEZA: Yes.

MR. HOFFMAN: Dr. Eisdorfer?

DR. EISDORFER: Greg and I usually agree. We have even done research on elder abuse together. I could not disagree more with his comments. I testified several times before Congress, and we were told by the NIH at the time that no one was interested in aging research and it was very clear. The reason they weren't is there was no money in it.

Now, there is a lot of interest in aging research. We were told there was no interest in geriatrics as a discipline, that doctors were taking care of older people, which I agree. Look at the Medicare bill. But only when we developed specific programs for geriatrics and funded them and agreed to fund fellowships, did they come.

So, I think this old rule about services, which is that care follows the dollar, needs to be extended to research. There's enough of the research community that would really move in the direction of this area if the money were there, and I do not have any doubts about that. I could give you a long recitation and, like Karl, I could be taken away from here moribund.

The issues now concerning human subjects have become extraordinarily difficult. As you probably know, within the last year or so, there are a whole new set of regulations about how to do research. There were some states, I understand Pennsylvania, where you may not be able to get access to certain kinds of records. But we're not going to make any movement, I believe, until the kind of programs that Dr. Stahl described begin to hit the research community.

And when there are fines and when there are initiatives, I'm willing to bet my entire nickel, my maximum bet, that you will have more than enough applications to be able develop a study section.

DR. STAHL: I absolutely agree with that. That is the intent of going after the NAS to begin a study, so that it gets some major visibility and so that I can make my arguments internally with NIA to get bucks from the director to further fund this. I agree. But it will be long-term. It won't happen tomorrow.

MR. HOFFMAN: Dr. Burgess?

MS. BURGESS: I wanted to add one thing to the IRB issue, that it's the populations that we would want to study are exactly the populations that are usually excluded from all studies for many of the reasons that you have said. So, it is going to be very interesting to see — we have a study we have to get through IRB, and it will be interesting to see — they have given us an assent form, rather than a consent form, consent being what is often used with children.

That is one thing that is suggested, because at the University of Pennsylvania, they have done a number of studies on restraint use with the elderly, so they have had to deal with the IRB issue. So, that might be useful for people to get feedback if that is becoming a major concern on going through IRB review.

MR. HOFFMAN: Randy Thomas?

MR. THOMAS: Yes, I'd like for a second to talk about this criminal justice research or that focused on law enforcement. It has been my experience, particularly being associated with the University of South Carolina and looking at the professors who do research up there, that it tends to chase not just money, but it tends to chase the glamorous issue of the year.

A lot of research is done on police pursuit. It is done on the use of force, a lot of the violence-related issues. Very little of it looks at process, how law-enforcement deals with victims, unless they are victims of violence. I do mean that in terms of homicide. It is very difficult, I think, right now, because I've had some of the graduate students approach me about trying to do research in the area of elder abuse.

It is not just a question of access. They get no support from the academic community. They tend to steer them into those glamorous issues that allow you to be a talking head as an expert on police pursuit, and the University of South Carolina has one that is always on TV about how we manage to crash cars. I've ever seen anybody from the law-enforcement community talk about this particular demographic.

I think it is also an awareness issue. People just don't realize that they are out there, they are being victimized. Some of these cases are interesting and egregious and would be worthy of research, but most of the students I deal with get discouraged from looking at this.

MR. HOFFMAN: All right. Carrie Burnight?

DR. BURNIGHT: As to whether there is interest in this topic in the academic community, not only geriatricians, that is, those with their M.D.s, but also people with their Ph.D.'s. My Ph.D. is in gerontology, and that is a relatively new phenomenon, although it's really starting to expand across the nation. I can say in the ranks there, there is a great interest in elder abuse.

It might seem depressing to an outsider or something, but the fact that we could actually get in something right now and make a difference, I think how appealing. That seems like the most appealing topic that there is, that there are all these people right now in their homes who are mistreated and that we would never find if we did not come together to do that.

So, I think there is a big interest, and I think that some people have expressed that they would like to, but the money is not there. So, they go for things that are epidemiological and already have funding and big data sets. But I think, if the funding was available, I think you have some very, very qualified researchers who would love to do that. And I think a wonderful partnership is the Ph.D. - M.D. combination in some of these research collaborations; that you need the clinical part of it, particularly for mechanism-of-injury studies, but then also the statistical analysis that is required to do these rigorous types of studies. So, that is the first.

And the second, with the institutional review board, having just gone through an approval process to get consent for people who would go through a multidisciplinary team is very hard, because you're thinking through tons of ethical issues. But, it can be done, and I think that is the main thing, that we can't shy away from studies because it is going to be so hard and tedious to get through the IRB.

The IRB is there to protect older adults and to protect all of us. So, I think you have to embrace it and say it is going to be very hard, but somehow this needs to be studied and we're going to do it. And if it takes the rest of my life of trying to get through the IRB, then we need to do it. I'm young, so I have my whole life for the IRB.

MR. HOFFMAN: Dr. Wolf?

DR. WOLF: A small comment, in addition to the IRB issue, there is the whole mandatory reporting issue. So, if you're working with an elder person who has been abused and it has not been reported, then the question is what do you do?

MR. HOFFMAN: Okay. Let me go to Dr. Lachs.

DR. LACHS: I just want to add to Sid's list, and it relates to a comment I made earlier. I hate to be a broken record, but again I think we need to sort of look at healthcare costs and outcomes as a feature of elder abuse and neglect. Earlier in this session, we heard people lamenting about the six-minute managed care visit. How are we going to pay for people to testify? How are we going to pay physicians to provide reasonable services to an elder abuse victim?

You know, it costs \$1,000 to sneeze in an emergency room these days, and I think that I'm thoroughly convinced that comprehensive primary care strategies avert those sorts of outcomes. I have no doubt, in my sort of clinical brain, that creating the CAGE for elder abuse — CAGE is an alcohol screening questionnaire — would sort of decrease health service utilization, a very popular thing these days.

And it is starting to be diverted to social work programs, the intervention studies which need to be done, I should tell you are very difficult to do. I mean, geriatrics now, after 20 years, is just starting to get outcomes data on things like falling and immobility. Everybody has concurrent chronic disease.

Adjusting for chronic comorbidity is very, very difficult. There is tremendous erosion of populations within the study for a variety of reasons. So, I just want to warn people that while these studies need to be done, they are extremely difficult to do and it requires sophisticated health services research.

MR. HOFFMAN: Dr. Pillemer?

DR. PILLEMER: Just very briefly on Rosalie's point and on the IRB. First of all, I mean, I've never found it to be difficult or, at least, ultimately impossible to convince an IRB, because they are also easily convinced of the value of the research and how there's no other way to do it.

So, I would say between those of us who have done research, we have probably eight or 10 or more studies approved which could be potentially very controversial. So, I would not let that stop anybody. Also, the federal government does have a procedure known as the certificate of confidentiality that people use in child abuse that we have gotten in several projects, which although I don't know how much it has been legally been tested, essentially exempts you from mandatory reporting.

In fact, it makes it illegal for you to report the case, so usually you are protected under that. So, that shouldn't be a barrier, also, to interviewing victims or their families.

MR. HOFFMAN: Certainly, from a law-enforcement perspective, that is a little disconcerting, for the good of the research as opposed to — when we deal with victims or potential victims and perpetrators and sort of remedies, whether it is in the community or in a institutional setting, that is a very difficult line for us to allow things to continue, especially where we see a system's problem, a systemic problem in a long-term care facility.

I mean, while there is hypothetically research being done on malnutrition and dehydration and development of pressure ulcers, while you have people suffering from these things on a continuing

basis is really — that is a tough thing to swallow without intervening in some fashion, whether it be a civil or criminal prosecution.

So, I understand what we're talking about, but I do not know how to best get at it.

Catherine?

DR. HAWES: I actually have some experience in this. We did a longitudinal study of a national probability sample of nursing home residents. Our protocol was we were using research registered nurses, so we felt that their professional obligation to report and our commitment to the well-being of the residents sort of superseded this issue of confidentiality.

So, what we did is in our recruitment we told every nursing facility and every board and care facility we went to that all responses were confidential except that — I can't remember the exact phrase — but we had the phrase, "except reporting as required by state law."

No facility turned us down because of that. They did not stop and think about it, but it is also that bad facilities hardly ever know that they are bad facilities. I mean, you know, it is just like a cognitive dissonance that is really fascinating, and they still let you in. And I think that I would personally be uncomfortable — what we did is we sort of had triage — if we observed abuse or a life-threatening condition, we were obligated to report it and to deal with it.

If we observed neglect that was going to lead to the resident's decline, we had a geriatrician on the project that we called to discuss the issues with and a geriatric nurse practitioner. And we then worked with the facility's medical director and the ombudsman to do address the issue, and that came up a handful of times.

So, I mean, I think there are ways to address it. You really have got to educate your IRB, though. I mean, it has just gotten worse and worse over time. And if you're under a funding mechanism that requires review by the Office of Management and Budget, your life is a living hell. I mean, that is a really serious issue.

Just to follow up on the high cost of poor care, there are a group of us that have been doing research in nursing homes and board and care homes for years, and the high cost of poor care is kind of the most encouraging thing you can do. You regard abuse and neglect as poor care and you're right. When you have got 30 percent of the residents getting emergency room visits every year, there is some money to be saved by finding out how to improve the quality of care.

That brings in a whole different group of researchers. I think Karl is right. There are a lot of us out there who would do this, but it will cost more than \$2.5 million dollars, a lot more.

DR. PILLEMER: That was just for the pilot work.

DR. HAWES: That is the measurement development. You pay that much to a sampling statistician.

MR. HOFFMAN: All right.

Greg Paveza?

DR. PAVEZA: David, I just want to come back to your point. As somebody who has used actually a certificate of confidentiality, and they have actually modified it a bit, the fact of the matter is that what really can't be subpoenaed, at least under the certificate, is the actual interview itself.

But what we say and what we were actually told to put by NIMH in the most recent application is basically if we believe that a person is an imminent danger from the physical facts that we see when we go in to do an interview, that we may have to make a report. And that is required to be in the consent form and we are required to explain it, in terms of what does this mean.

But, what can't be drawn from us if we should even make a report is the actual confidential information provided in the interview itself. So, I think again it is doable. It protects my staff. To some degree, it protects the participants. It is a tricky ethical line and we're not going to get around that when you're dealing with this type of suffering where there is true damage to human beings caused by other people, it causes problems.

But the people in criminal justice, by the way, do it all the time when they do their research. I have one colleague who has six certificates because they're looking at things like homicide and asking for confidential information from people who have committed homicides about information about how they committed the crime.

MR. HOFFMAN: Sid?

DR. STAHL: Well, just to follow up on the IRB business, my portfolio right now is about almost \$2 million each year in elder abuse and neglect grants and every one of them has had some difficulty, but everyone has been absolutely successful in going through IRBs. Secondly, it is a requirement of almost every one of those IRBs that if indeed they suspect that something is amiss, that it be reported, and that hasn't deterred their research.

MS. VETA: David, following up on Sid's point, as a number of people have indicated, \$2.5 million dollars is just to do the pilot data. We need a lot more, but also the point is that it certainly is not going to happen overnight. Given whatever research dollars are out there now, what are the highest priorities? What should folks be doing right now to advance the research agenda, to move toward the \$2.5 million and above?

MR. HOFFMAN: Dr. Dyer?

DR. DYER: Recently, I went and I met with Dr. John Burton, who is chief of geriatrics at Hopkins, and told him what difficulty I had in getting grants funded at the national level. The studies that we have done on dementia, depression and the database analysis, we have had to piece together from either people volunteering their time or small grants from the development office at the college.

And he told me, he said, "Look, the area is just at the level where delirium, which is a big geriatric topic, was 10 years ago." He advised me to keep working in the area, go to the small foundations, try to piece together pilot data, and that way you could develop the research agenda. And I just, for my second point, wanted to talk about the IRB issue.

Basically, Dr. Pillemer, when you're doing studies where you are just talking to patients and just administering tests, it is a little easier to get through the IRB. If we talk about implementing medical treatments or drawing blood or putting them through a long-term medical care program, that is a different story.

The other thing is we have gotten through our IRB successfully, although it wasn't funded, but where we read the consent to the patient and we have them recite back what we're trying to get at and we do not have any proxies signed that may be the perpetrators. So, by promising that, we have been more successful.

Lastly, David, to your point about why things seem obvious, do we have to prove them. The tradition in medicine is that even though there is prima facie evidence for a thing, I mean, it only makes sense that an interdisciplinary team should take care of elderly patients, we have to show proof at multiple sites and in multiple studies before it is accepted by the medical community.

MR. HOFFMAN: Dr. McFeeley?

DR. MCFEELEY: I was just going to reiterate what you said before. I think one of the most important things we can do besides intervening, and, I mean, I think it is clear to all of us that there is a problem and it needs to be helped and you don't want to just do the research to find out about it. You want to be doing something to prevent and mollify the problem.

But I think the prevalence issue is really important and I keep hearing this, "Well, you know, we're talking, it's not very common. It's going to take a large study because it is rare."

We don't know that and that is not my field. Actually, it may not be nearly as rare or uncommon as we think, and that is covering the whole gamut, you know, if you're talking about serious emotional abuse all the way through till death, you know, and physical abuse, there is probably a much larger group out there, and although that may be the most difficult study to do, and I don't know how you go about really coming up with a good prevalence.

I think that is probably one of the most important things we can do to start, because if we don't know what is there, it becomes very hard to try and decide how deep the problem is and what we can do about it.

MR. HOFFMAN: At the risk of opening a whole other can of worms, how is it possible, given the child abuse experience and the domestic violence experience, how is that we sit here in the year 2000, that this is such an unknown? I heard this when I was at the Department of Aging in 1987, about how far behind elder abuse was.

Am I missing something? How are we at least 20 years behind? I mean, you hear ageism. You hear that it is a difficult cohort. But it is just mind-boggling to me.

DR. PILLEMER: Based on the prevalence estimates we have from studies all over the world, that compared to other forms of family violence and compared — or of interpersonal violence — and compared with other enormous problems the elderly experience, the base rate of elder abuse, that is active elder abuse, is relatively low.

And that is one reason why I think it hasn't seemed as absolutely compelling. I think you're right. Like when I wrote up my remarks, my little paper for this, I went back and looked at my comments about problems in the research base from a conference in 1987 and they're pretty much the same. But I think the other problem is that a constituency has not congealed around elder abuse in the same way that ones did around child abuse and the abuse of women.

I mean, the interest in the abuse of women was attached to the feminist movement and the rise of sort of interest in women's issues, in general. With child abuse, the pediatricians latched onto it, as did social workers. There hasn't been a constituency. Major national organizations like the AARP or others don't find it as attractive an issue because it doesn't emphasize positive and successful aging. So, I think it is a combination of those.

I promise I will shut up if I can say just one thing. You raised a very interesting point, Dr. McFeeley, and that is what I hear again and again, which is, well, even though we do not have exact research

on what we're supposed to do, we practitioners have to do something. The problem is that dating back to Mark Blankner's early research, we really don't know if a lot of these intervention programs have perverse effects. I mean, there is no evidence at Adult Protective Services — there's no hard scientific evidence that people, in general, are helped by Adult Protective Services.

The only study which exists is one that shows they are disproportionately institutionalized and tend to die more frequently. So, it is not an idle question, the push just to do something without knowing exactly whether it is the right thing to do or not. We run the risk of very dangerous consequences without really seeing what these programs are doing.

So, that would be the way I'd answer that question, even though I know it is a dilemma, because we do feel like we have to do something.

MR. HOFFMAN: Dr. Eisdorfer?

DR. EISDORFER: In the life span of most of the people in this room, we believed that dementia in later life was, A, caused by hardening of the arteries, B, was inevitable and, C, was untreatable. We now call it Alzheimer's disease and obviously none of those three are true. I know about a four-to-five-percent prevalence rate, but I also know that everyone reads the studies as critical.

I have no clear idea in my head as a scientist whether we're looking at the tip of the iceberg or a mountain that I can see the base of. I think that, underscoring the issue, we really need to know how much of a problem we as a country or the world has with this. Secondly, I would venture to suggest that as part of that, in addition to that, we need to know what the risk factors are. And we do have some problems with the IRB that are getting worse.

Most of us have IRBs, but dealing with a group that is demented and dependent is very tricky under new IRB's. And here, we need a collaboration between the legal and the scientific/medical profession. Have we approached a group like this, which may have compromised ability to give informed consent — but I think the critical issue for me is we really are in a swamp, in a fog, at night, looking for a door that may or may not exist.

So, I know of no way to approach this better than to start putting a light on this area and begin to assert that this is an area that should be of a national priority. It has tremendous impact, not only abused individual, but on the family and, I believe, ultimately on the community. So, I would add one other thing. I think, as with a number of other issues, we have got to get this on the public agenda.

Now, I would suggest that the Attorney General give a talk and get on 20/20 or — I know we're in an awkward situation right now with administrative changes perhaps or perhaps not — but I think this has got to be raised to the public agenda and I would suggest what happened in aging and Alzheimer's and heart disease and cancer, et cetera, et cetera, is a direct consequence of the fact that we have got a public interest with a political response.

MS. CONNOLLY: I'm interested also in people's reactions to Dr. Pillemer's suggestion earlier that there be strings attached to dollars for various intervention programs or whatever else, requiring there to be a study component. Do folks agree or disagree?

MR. HOFFMAN: All in favor? All opposed? All right, there is one.

DR. MOSQUEDA: I think the point is well-taken and it is important, but this is really where we really need to have consumers, if you will, involved in making the decisions; that it cannot just be us

sitting around this table, calling for what research needs to be done, how it should be done, the priorities for it and that we cannot do anything more until everything is researched, because my experience in having consumers on research advisory boards is they will push us in directions that we are uncomfortable with, very uncomfortable with, that are not scientific.

Yet, I think they need to be heard and we need to understand the points of view of some of the elders who have been victims of abuse and some of the family members. I think some of whom will say, "I want you to do the research, but, damn it, if you wait until all this research is done until we do anything to help, even though we have to admit up front we're not sure if we are always doing the right thing, then I don't have 15 years to wait or 10 years to wait."

So, I think I agree with what you are saying in principle, but I think there also needs to be a practical approach done in concert with it that won't stifle the ability of people sort of in the trenches to continue forward with some of the work.

MR. HOFFMAN: Lisa?

MS. NERENBERG: I definitely agree with Karl about service programs having outcome components and research components attached to them. But a lot of private foundations, even the United Way, now are requiring service programs to do evaluations on their effectiveness, and there is a lot of nonsense out there. I mean, a lot of us are being asked to do evaluation without being evaluation researchers.

So, I think there is a real need for researchers to put out plans for doing research that service programs can realistically do.

MR. HOFFMAN: All right.

Dr. Sanders?

DR. SANDERS: I'd like to just reinforce what Mark said in the previous session. But I think we need to take it seriously in terms of medicalization of a social problem. How much do we want to do this, because it is basically a social problem and obviously there are medical consequences, depression, broken bones and things like that?

But there are other social problems, from traffic accidents or traffic crashes, gun control, violence in our schools, violence in our society, drugs, that we all see medical effects of. When I was a medical student 100 years ago, it was basically the nuclear armament race. It was sort of medical — medicalization of nuclear controls or antinuclear movement.

Again, in some ways, it is pushing it if you look at that. And so, in some ways we need to say how much do we want to medicalize it and hold it to the same standards that we do looking at cancer drugs or, you know, acute myocardial infarction or things like that. That really hasn't been answered for this, and I am not sure we're that far behind other things that fit into this, such as other forms of domestic violence.

I think child abuse has a greater literature, but other forms of domestic violence, at least from my point of view as a non-researcher in that area, is up in the air. There are a lot of true believers. You have to screen everyone, but the data is just not there and there are very few real hard studies of it. And similar sorts of things which are social problems and have medical effects.

MR. HOFFMAN: Dr. Burgess?

MS. BURGESS: I just wanted to say that there are studies that are going on. There are some numbers. Mark Safarik's study down at the FBI Academy — he is one of our observers — he is looking at over 100 cases of serial sexual homicide of elderly females. I think there are some very important lessons to be learned there.

We've been looking at sexual abuse of nursing homes — residents. 1,749 cases have been reported in a two-year period to the long-term care ombudsman's office. These numbers are going up. There is every reason to believe this may be another hidden area of rape, and these are cases where somebody usually has to observe a rape in progress for them even — and these are adjudicated cases. These are completed cases.

So, I think that if we start putting the spotlight on it, as people are saying, and pull together the descriptive studies — I mean, research starts with good the descriptive studies. It does not have to always start with the empirical studies. That comes a little bit later when you get some good hypotheses that you want to test. So, I do think we have a beginning group.

There is another research area that showed that social workers knew of rapes occurring in the home of elderly and they tended to be husbands and sons. That is the first time I have ever heard of sons raping a mother. That has been reported in the descriptive literature. So, there are some very interesting things that I think should be looked at.

MR. HOFFMAN: Back in a former life, I prosecuted a son who sexually assaulted his mother.

DR. DYER: Our data show that a lot of elderly patients who neglect themselves are demented and depressed and have degenerative problems, but our data also show that if you suffered from self-neglect, that you were much more likely to suffer from physical abuse, verbal abuse or sexual abuse.

I think the underlying geriatric syndromes, the medical problems, are a great risk factor for physical and verbal and sexual abuse.

MR. HOFFMAN: Dr. Hood?

DR. HOOD: I would just like to say we seem to be talking about a lot of money on the large prospect of Framingham-type studies. I think we have missed fixing what is already there, but not working very well. We have Adult Protective Services. We do have some data, at least on the adjudicated incidents through the police records. We will admit that those are obviously low and not a true reflection of what is really going on.

I think Adult Protective Services probably has the best handle on it, but I rather get the impression that the type of record keeping is spotty and it is not the same from jurisdiction to jurisdiction. We're in much the same state there as we were, say, with highway accidents 40 years ago before NHTSA got a standardized reporting form and started telling the states that if you want money, you must provide this data in the form that we want it on every incident that you deal with.

That is both a carrot and a stick approach, which seems to have worked very well in getting at least reasonably good data on motor vehicle accidents, drunkenness and its effect in them. And I think much the same thing could work with a system that at least is already in place and may be able to be gotten up and running and standardized a lot quicker than spending a great deal of money on a study that may take 10 years to come to fruition.

MR. HOFFMAN: Dr. Lachs?

DR. LACHS: These need not all be expensive studies in terms of bank for the buck. I think the things that Carrie and Laura were describing, I mean, the basic descriptive studies of how ecchymoses evolve over time; a radiologist looking at 300 or 400 consecutive fractures blinded to whether or not they were sort of physiologically obtained versus abuse and then creating a two-by-two table and calculating sensitivity and specificity.

I mean, those are not large, you know, 10-year elder abuse Framinghams. I think if I were going to concentrate some modest resources, that might be a very good place to start. I mean, we really are at the sort of descriptive stages of the syndrome and intervention studies are going to take much longer and cost much more money.

DR. BURNIGHT: I think part of it is just that there has not been the systematic approach to it. I think things have been done and I'm hoping that maybe — that Dr. Stahl talked about in the panel — that we can start to think what exists and then a step approach and not something that you need to necessarily wait 10 years for. But we need resources and we need to be systematic about it, because it seems like all throughout our discussion we kept thinking of, "Great. Oh, if we knew this, if we knew that."

Well, if we could get to a systematic way of writing down those areas or those questions. As Dr. Wright talked about, too, of not starting at the end, but just starting where we are now and just systematically plugging through. Our sophistication — we are not there yet.

DR. MOSQUEDA: We're just going to take two more comments from Dr. Wright and then from Dr. Hawes and then we will begin the wrap-up.

DR. WRIGHT: Mine will be short. I think one thing I was going to say in addition to what Dr. Lachs says is doing some of the small studies can be done on a larger scale, given the fact that we have the Internet and we have telemedicine now. We have a list serve in pediatrics where pediatricians who are certified experts, if you will, in child abuse communicate with one another.

When everyone has an idea, we will put it out there and someone will say, "Who wants to collaborate on a multi-site trial?" It might even be just a retrospective review of something, and if you do the same thing cheaply at five or 10 different sites, you can maximally increase your numbers and get more data out of it.

So, I think one thing that could be learned is to take, since it is just beginning and is in its infancy of starting some of the work, to do it on a larger scale even if it is retrospective work or something to start with, first take advantage of what is out there from the Internet and the technology that we have these days.

DR. HAWES: I think the other thing is to go to some of the other big funders. I mean, the assistant secretary for planning and evaluation, HCFA, those are the agencies that have a lot of money. So, they might fund different kinds of studies than NIA and AHRQ would fund, and somebody ought to get the agencies together, talk about what kind of research agenda we have and figure out how to divide up the pie of questions among the agencies.

MS. VETA: I think this discussion of research has been quite valuable and some of the take-away points that I have heard are, one, we need increased funding; two, we need collaboration; three, there are some things that can be done in the short term to advance the field, such as the kinds of studies Dr. Lachs mentioned and also using some of the new technology that Dr. Wright mentioned.

I just wanted to jump in here to give you a preview of what our next session will be, and that really is to focus on what kinds of things you all have learned from today's session. I know that we here at the Department of Justice have learned an incredible amount from you and we really appreciate it. But when you all meet with the Attorney General at three o'clock, and I want to come back with that, she is basically going to be interested in three things.

One, she is going to want a quick summary of the substantive points that were covered here. Second, what she is going to be very interested in is what it is that you all learned or what it is that you plan to do differently as a result of this forum. She is, as you all know, an action woman. And although she appreciates talk and discussion, she is also very concerned that the talk gets translated into action.

You all around the table are the most action people, I think, in the country on this. So, she is going to be very interested to hear what it is you plan to take back. And then the third thing is to share with her the recommendations that you have for the Department of Justice to follow. Although, obviously, the "think-big" should be in there, and to the extent that you think there needs to be increased funding by orders of magnitude, I think she needs to hear that.

But, by the same token, if there are concrete, manageable things that can be accomplished in the short-and medium-term, she is going to be very interested in that. So, the other thing I would say is although she is now scheduled to be here at three o'clock, she is also usually very prompt and sometimes early. So that we can take advantage of every minute that we have with her, I would suggest that once you finish this next session taxation and take a break, that everybody be in their seats and ready to go at about 10 till 3:00.

I'm going to need to excuse myself in a few minutes, but I will see if I can listen to the first part of this next session.

DR. MOSQUEDA: So, I think what we're being asked for here is just if people could maybe tell us a little bit about some of the take-home points, some action items that you think you may do differently or perhaps some new things that were brought up at this session that will influence you when you leave here.

Dr. Stahl?

DR. STAHL: The possibility of NIJ and NIH indeed cooperating together on funding research on topical areas.

DR. MOSQUEDA: Dr. Wolf?

DR. WOLF: I was thinking of a national forensic center and the fact that probably there may be one national and later on maybe regional one.

DR. MOSQUEDA: Patti McFeeley?

DR. McFEELEY: In speaking of a national forensic center, I mean, I'm not sure what was meant by that. There certainly are crime labs and there are sort of regional forensic centers around. At one point, we sort of mentioned that people should be able to plug into forensic expertise.

But I think many of those are already in place on a local or regional level. Now, it may be plugging into those and utilizing those in a way that they have not been used necessarily just as a crime fighting or law enforcement technique, but to utilize them in investigation may be really what we

need to do. I mean, I think we need to utilize them, but it may not be re-establishing something that may already be in place.

DR. MOSQUEDA: So, that people sort of agree that the concept is good, how we might do it either by creating something new or building upon what already exists.

Lisa Nerenberg?

MS. NERENBERG: Maybe a starting point would be a computerized database so that they can find each other and other practitioners or start a dialogue online.

DR. MOSQUEDA: Bill Hauda?

DR. HAUDA: One issue that came up repeatedly was different localities have different areas of expertise, and even within certain jurisdictions, there is a wide variety of abilities, whether it is rural, whether it is urban or suburban, which agency is investigating the case? Are they going to work with certain people or not work with certain people?

I think taking that sort of to the next step, not only just having sort of a repository of information, but having people who are available to act as models, how they have set up programs and sort of disseminating that information. We have talked about multidisciplinary teams, which is one approach, but it is not necessarily the first approach, which is really to get the experts there just to help law-enforcement with the initial investigation so they're getting their feet going on the ground.

The next step, obviously, is taking on — even some of the simple cases, I'm sure, were missing, where it is just physical assault that is happening or it is a rape that is happening and we just don't have the experts to help with those cases. I agree, it would be nice to approach all the most difficult cases, as well, with the financial issues, the neglect, was it self-neglect? Is it having a nursing home at home?

But even some of the simple, straightforward cases that we have gotten very good at in pediatrics of just recognizing in the emergency department that there is no question it is abuse, we are not even there with elder abuse yet. I think at least having the Department of Justice act as a clearinghouse for how to set up a program like that, a forensic center, experts in documenting the abuse and helping law-enforcement decide where to go with that information would be very helpful.

DR. MOSQUEDA: Erik Lindbloom?

DR. LINDBLOOM: From the educational point of view, the importance of cross-disciplinary education, at least from the Department of Justice standpoint, is what can be done to enhance cooperation between law-enforcement and the medical profession and social workers and APS. We could learn from law enforcement what we need to do to collect the information needed to enforce these cases and to increase awareness.

DR. MOSQUEDA: Dr. Hawes?

DR. HAWES: I'd like to see the Department of Justice establish a permanent task force to deal with issues of elder justice. It has been pretty remarkable between this conference, the state working groups that have been put together, and it would be nice to maintain that momentum and institutionalize it so it doesn't just drop away.

DR. MOSQUEDA: I think one thing I'm going to take away to the American Geriatric Society is to say that there's general agreement that geriatricians need to know more about elder abuse, and certainly in my home institution make a greater effort to do more training in it, but also to push our organizations, which many of us are members of, to do more education where I think we'll have an easier time, also, on the evaluation component in getting agreement to have an evaluation component of it, also.

Candace?

MS. HEISLER: I would like to build on some of the database points that were made. I learned about a number of programs around this room that I'll bet a lot of us didn't know about, and I'll bet there are dozens more that we have not identified here today. I would like to see the database we're developing have examples and listings of what are the current various programs that are out there, contact person, various models for how to do different tasks, different training curricula and resources and resource materials that have been developed under a single heading where we could put our hands on them and identify them.

DR. MOSQUEDA: Sue Ren?

MS. REN: Just to dovetail into the topic of education, I heard a lot about training, but also about developing strategies to change curriculum in schools, for nursing schools, social work, medical schools that I think Dr. Sanders was talking about, developing that pyramid or where should the education change? Where should it start? Not training after people have already gone through their education.

DR. MOSQUEDA: Dr. Pillemer?

DR. PILLEMER: I'm not entirely sure how to sum this up into a recommendation, but maybe somebody can help me. I was struck by, and I think this came up in each one of the sessions, but the need to somehow develop a constituency of interest in this, or to get the issue on the public agenda. And I guess ideas could range from having someone like Janet Reno or other prominent people use sort of a bully pulpit to increase interest.

As Mark and others said, actually documenting the actual cost of elder abuse and the prevalence which, even if it is not huge, is certainly dramatic enough and involves enormous human costs and economic cost. If there's just some way to work on important constituencies to bring this sort of higher up on the public agenda, through any number of mechanisms, I guess that is one thing I've taken out of this.

DR. MOSQUEDA: I'm hearing a lot of very broad ideas. Is there anything you could go and do tomorrow?

DR. PILLEMER: Come up with that \$2.5 million.

MR. HOFFMAN: I have \$50 in my wallet.

MS. CONNOLLY: We will take it.

DR. HAWES: I'm going to do one thing, not tomorrow, but next week. We are one of six world health research centers in the country funded by HRSA, and one of the things HRSA has asked the School of Public Health at Texas A&M to do, Rural Public Health, is to identify a handful of objectives of

Healthy People 2010 that are particularly relevant to rural areas. Since I'm the director of it, I guess I can at least choose one.

And I'm thinking we should probably choose dealing with, recognizing and addressing elder abuse in rural communities. One of our charges is to identify best practices, to help health departments understand how to put it on the public agenda and raise community awareness, and then to give them tools to address it.

So, after we recruit Dr. Dyer to move to Texas A&M from Baylor, we will begin this.

DR. MOSQUEDA: That is very subtle.

DR. HAWES: We do not have time for subtle; do we?

DR. MOSQUEDA: Randy Thomas?

MR. THOMAS: I'm going to put Bill Gambrell on the hook. He and I talked a little bit about possibly going back to our state. We are fortunately blessed with two medical schools, one down in Charleston, one up in Columbia, and do our own modified version of — I do not know if you could call it a forensic center or not — but see if we can develop some contacts.

I know MUSC in Charleston has a fairly large forensic pathology operation and see if we can at least capitalize on it. That is something we can start whenever we decide to go home. Right?

DR. MOSQUEDA: Dr. Stahl?

DR. STAHL: We can't do it in two weeks, but we can probably do it in six months. We can probably do an analysis with the social research community of those interventions that actually work. That has never been done before. We do not have a compendium of those sorts of things, and that would be a fairly easy way to get a leg up on what works and what does not work.

DR. MOSQUEDA: Dr. Eisdorfer?

DR. EISDORFER: My intent is not tomorrow, but Monday to call the law school and we do exchange lectures occasionally around the involuntary commitment and so on. But I would think that trying to develop a joint program, at least, of course, that could be used both by physicians and law students, would be a very interesting start.

The other is to talk to my director of CME. Again, we have had the occasional elder abuse colloquial, grand rounds, specifically, but I think developing a series of short courses through our MAGEC, Miami Area Geriatric Education Center, which is a national network, if we put that into the national agenda, that could certainly move forward.

And then the toughest one, but I have not figured out how to do this, would be not to go to the head of geriatric medicine, but to go to three to four chairman and get this put into the residency program. As a physician, I would tell you, that's where this training needs to be, at the bedside, at the level of the resident, not the medical student that needs to know about it — but I think the residents are the ones, and the fellows, ultimately, will profit from this.

DR. MOSQUEDA: Dr. Hawes?

DR. HAWES: We are doing two projects for HCFA right now on the complaint investigation project and the use of the nurse aide registry to prevent abuse and neglect. Those reports should be out by the summer of 2001. They will identify and make recommendations to HCFA and the states for changes they should make to their current processes. It would be good to get input from all of you all about suggestions for how you think your state could function more effectively — or good practices that you have.

DR. MOSQUEDA: I will also mention, Dr. Burnight and I are working on a proposal right now to our state for funding using a randomized controlled design on, sort of, development of a forensic center in elder abuse. So, we will know about funding probably in about a few months. Joanne Otto?

MS. OTTO: The National Association of Adult Protective Services Administrators, NAAPSA, will be conducting a study of the adult protective services programs in this country. I would be very interested in hearing from people about where you see the gaps in your particular regions or states or whenever. Because we are really trying to get a holistic look at what response system do we have now and where do we need to go with it.

DR. HAUDA: This is a little longer term project, sort of in the intermediate phase. It is probably going to take us about two years to although the funding is there. Virginia has change legislation one of the codes for payment of medical fees for investigating crimes, so that in addition to sexual assault exams, in addition to physical assault exams of children, any evaluation of a person who has been a victim of a crime is paid for. So, for elder abuse, if we have a case that is identified, we could have a medical provider paid for doing the investigation.

However, the issue now is there are no guidelines for it. There's a task force that did the same programs a number of years ago. Two years ago, there was a task force that did the pediatric part of it. And the task force for adult part of it has not been put together yet, and it is something we're struggling with the Commonwealth of Virginia. My guess is it will take — it took the pediatric component two years to do it. It will take at least that long, obviously, with the complexity we've talked about for elder abuse to be approached as well, as well as domestic violence, which would fit in that as well.

So, we have some opportunities to use funding that is there potentially there already, assuming it does not get taken away by the time we get the programs together. But that is something were going to work on in Virginia, like I said, at least over the next two years.

DR. MOSQUEDA: Okay. Well, I think we're going to wrap it up at this point, so that we have a little — a few minutes for a bathroom break, etc.. And we will reconvene very promptly at 3:00. At 10 till three. I have been told. Okay. All right.

[Recess.]

MS. CONNOLLY: I know some of you have mentioned over the course of the day that we would want some sort of an organized national agenda, and I'm wondering if perhaps while we're waiting, if there are further thoughts, either looking to the area of child abuse by illustration or that other of you have had, how we start that process. I think Dr. Stahl has given us one cornerstone. Sorry, two. Dr. Pillemer?

DR. PILLEMER: I have realized that for some of us who are more sort of academic/gerontology-types, what, sort of, really understanding what forensic science is and what you all know and what the key issues are and how you go about doing your work. I mean, I hate to think of another conference on top as my recommendation, but it does seem to me like their could be really strong

grounds for collaboration from people doing either basic applied research in gerontology and people interested in these forensic issues.

I think it is two areas that do not talk to each other an awful lot, either at the federal agency level or in terms of our own individual practice. So, I think maybe more of the same would be useful with substantive presentations from people about the kind of work they are doing. At least, that would certainly interest me.

DR. MOSQUEDA: As long as you have evaluation data to prove that is a useful thing to do.

DR. PILLEMER: There are statistics on this, and if not, I could make them up.

[Laughter.]

DR. HAWES: That is the kind of multidisciplinary research that is much broader than most of us do.

MS. CONNOLLY: At this point, we have the great honor of having the Attorney General join us. A few weeks ago, my four-year-old son, Gabriel, got into an argument with some big boys on the playground. They were doing things he did not like, and he said to them, "If you don't stop it, I'm going to tell my mom, and she has a really strong boss."

[Laughter.]

MS. CONNOLLY: And, in a sense, that is why we are all here. Because it makes an immeasurable difference to have the support and involvement of a really strong boss who is willing to take on the difficult issues, such as this one. Ms. Reno, you have demanded that we expand our definition of law-enforcement to include prevention, intervention and prosecution, and that we, as prosecutors, find better ways to work with the health-care providers, the social service providers and public safety professionals, so that we can achieve meaningful results.

I cannot say that in every playground squabble, that my son, Gabriel, is flying on the side of the angels, but I can say with great certainty that having the support and involvement of this Attorney General has already made a great difference, and that it will continue to make a real difference in our ability to tackle this confounding issue, and for this, Ms. Reno, we all thank you.

It is my great honor to introduce the Attorney General of the United States.

[Applause.]

ATTORNEY GENERAL RENO: I'm not the reason you're here. The reason you're here is now almost 15 years old, when I went to see Dr. Eisdorfer about a child abuse case, and he took the occasion to start talking to me about elder abuse, and I started focusing on it, and he talked to me about the problems associated with forensic work in elder abuse.

And I have been trying to work on it to figure out how we could be effective in the Department of Justice and, if I had a dream, a good dream, a wonderful dream, and the dream came true, it would be you all sitting around this table, because to look over and to see a pediatrician here is perfect, because I see so many of the similarities between what we faced when we first really started investigating child abuse and the forensic implications of it, and the desperate need for strong forensics.

And then, when I hear about you, Dr. Dyer, and what you're doing at Baylor and so many people around the table, it's a wonderful dream come true. So, I am here to listen. But what I want to try to do is talk in terms of this abuse as I have about all. What can we do to prevent it in the first place? How do we structure an economy, a social service delivery system, that enables people to be strong and self-sufficient?

I see so many instances where proper service and care can make a difference. We're coming to a service society. We could do so much more in terms of developing whole new careers for service. What can we do to intervene in that first example? How can we work together with community police officers who are sensitive to the issue, who know what signs to look for and who are sympathetic to the care giver, as well?

How do we prosecute? How do we put these people through what everybody will recognize is a traumatic experience unless we are very, very careful in terms of protecting them? How do we have the forensic experts who are willing to testify and to sit around and wait for court, and then to have the case continued and then to be told they have to come back and then have some defense lawyer act like a —

[Laughter.]

ATTORNEY GENERAL RENO: And then what do we do when we convict a care giver who cared and who had reached the end of their rope, and what are the alternatives and how do we send the message? And then how do we provide services to the care giver so that they better understand how to do it? There is so much. I have a dream. If I had been at Harvard Law School today, I would have demanded that they have a law degree that was obtained in conjunction with the School of Public Health and probably several other disciplines.

There is just so much we can do in terms of elder justice, as I have come to call it, and I just cannot thank you all enough. I know some small measure of your schedules and I just am deeply intended and very touched that you would take the time to participate, as you are today. So, I would like to listen and have one overriding question: If you were the Attorney General of the United States, what would you do to address the issues that you raised today and what more can I do to press the issue of elder justice, both while I am here and when I leave here?

DR. MOSQUEDA: Thank you, Ms. Reno. David and I will give you a brief summary of today's events, and then we will really open it up so that most of the time can be spent for you to be chatting with this distinguished group.

I think one thing we recognize, especially with the benefit of a pediatrician here, is that we're probably 20-to-30 years behind the science and the education and the clinical practice of child abuse, and that is a shame. We recognize that elder abuse is a particularly difficult and complicated issue. There is no uniform presentation.

There are no standard treatments. We need to understand the issues within the victim and the perpetrator. And it will very much depend on the type of abuse. There are so many different types of abuse that can occur. But I think the other thing that came up today is the importance of understanding the context of the situation in which the abuse occurred in order to do the right thing.

And the right thing will include things like treatment and prevention of further victimization, helping both the victim, I think in many cases, also helping the perpetrator. Although we have discovered, I think all of us, through our practices that it is very difficult to have sort of a slam dunk, if you will, that when somebody comes in, that this was definitely elder abuse. There are certainly obvious things that we can agree upon.

If somebody comes in, for instance, with cigarette burns or ligature marks. But these are really the rare cases. What we did agree upon today is that there are certain markers that ought to trigger us to look further into elder abuse for the possibility of elder abuse, markers such as malnutrition, dehydration, pressure sores, bruises. These are all markers that should make the clinician ought to look further, but I think the other area that we see of difficulty is what do we do next when we see these markers and then how do we do it?

I will let David address a little bit of that in terms of our interaction with law enforcement.

MR. HOFFMAN: Okay. I also want to thank you for being here today. I am just an AUSA out of Philadelphia, one of your worker bees.

[Laughter.]

ATTORNEY GENERAL RENO: You are a lot more than that.

[Laughter.]

MR. HOFFMAN: From a law enforcement perspective, and I'm not certainly going to tell you anything that you're not already familiar with, the big issue in bringing cases, whether it be in a criminal prosecution, on a state or federal or local level or a Civil False Claims Act prosecution for neglect is the issue of medical causation.

And we discussed the issue of how we would prove that and what is necessary in proving medical causation when someone appears from a long-term care facility with multiple pressure ulcers or suffering from malnutrition or dehydration. And we rely on the testimony and documentation of experts and a lot of the people around this table would qualify as experts that we would have testify in front of the jury.

We would also need to respond to the defenses that we hear, especially when, for example, someone does appear in an emergency room from a long-term care facility and yet the hospital sends them back. I mean, that is sort of an inherent defense. If we were to charge a facility with criminal neglect, one of the first things we may hear is that if it was this bad, you had plenty of medical testimony, medical expertise in an acute care setting, how can you conclude that we neglected these individuals if, in fact, the hospital felt it was a safe enough discharge or transfer.

What is clear is that we need more expertise in this area. We need more experts. We don't have a whole lot of expertise out there at this point in time, but it is an area that I think is something that was identified as potential expert testimony in order to prove the medical causation piece of our cases.

We also talked about once things have been identified for further investigation — we talked about the use of multidisciplinary teams, because these are complex cases. And no one entity can do this alone and conclude that there is abuse or neglect. It is a total picture that needs to be put together, and as a result of that, there was discussion about tailoring multidisciplinary teams, figuring out what the goals of the multidisciplinary teams are and then who should be a part of those teams for investigative purposes.

DR. MOSQUEDA: There was quite a bit of discussion about multidisciplinary teams, and I think the general consensus, if there was one, that depending on the goals of the team, you would then have to define who the core members of the team need to be. An interesting discussion, I think, came up

about the need for forensic experts on the team, which hasn't occurred to certainly myself and, I think, perhaps others. And we also had some discussions about some teams in existence.

I'm involved in one where we do have law enforcement. Our district attorney, medical community, Adult Protective Services all involved in regular meetings, and that we see benefit in that. But, I think as will be discussed later, we need to prove the benefit of these teams, because they can be expensive and unwieldy and we really need to know they work.

This led us into discussion regarding education and research, what education is being done and what education needs to be done. And, as a general concept, I think I will use the term of an education pyramid was discussed, that no matter what field you look at, be it geriatrics or social work — let's say medicine, social work, psychology — that when you start at the student level, there might be just some general knowledge that needs to be taught, and that as you work your way up the pyramid to graduate level and then more and more specialization in the area of geriatrics, more specific information needs to be taught as it relates to elder abuse, and that perhaps we need to better define what ought to be taught at these different levels of the education pyramid, looking at more advanced issues, the more advanced the student or the learner becomes.

And I think, finally, the area of research really had some vigorous discussion. One, the sad fact that there isn't a lot of good research and some discussion as to why that is the case. You will be shocked to hear that one of the issues is funding. And I think that one important gift that you can give all of us is to help emphasize the need for funding, not only from this department, but from other agencies in the federal government, and, as will be discussed later, I think the need for interagency funding and research to be done.

I think with that, we really have a group of experts and I would rather let them define the issues in more detail. We just wanted to give you some of the broad brush strokes. Is that okay?

ATTORNEY GENERAL RENO: That would be great.

DR. MOSQUEDA: I think we will lead off by asking Dr. Carmel Dyer to discuss her —

DR. DYER: I would like to discuss how we can promote elder mistreatment education, and I think we have to really set three goals to accomplish our overall aim of promoting education, and that is although everybody here understands the importance and the value of learning about elder mistreatment, I think we have to prove that value to academic medical centers and others.

And we have to convince the academic medical centers to take this on as a charge. Lastly, once we convince them of these things, then we have to something for the learners to do once they have the basic knowledge. I think we can accomplish these goals by doing two things: One, increasing the research; two, making some policy changes.

Towards the goal of proving the value of elder mistreatment education, we need to make elder death more noteworthy. It needs to not be just something that happens to old people. We need to raise that in the public. We have to prosecute alleged perpetrators, particularly those of care giver neglect, and we have to train more elder mistreatment experts. But, in particular, what if we said to every medical school in the country, "Please identify one elder mistreatment expert at your school?" Just doing that, I think, would raise the level of this issue on the radar screen for them.

The second goal of convincing the academic centers to go forward is that we have to attach some other important things to the issue. For instance, Medicare dollars are very important to the academic medical centers. But we are using Medicare dollars to train non-geriatricians or, for

instance, obstetricians. And so, with the changing demographics, can we build in incentives in the Medicare funding to promote the training of more geriatricians?

The other thing is we have to convince doctors and nurses that elder mistreatment is not just a social issue. It is a social issue and a medical problem that, requires those of us from different disciplines to work together, to improve the lives of older people. Lastly, there needs to be more geriatricians in leadership positions. We have to be on the curriculum committees. We have to be in positions of leadership at the college level, sitting at the tables, deciding what the students learn.

But the way we can do that is if we produce grants and research, because those two things are the currency of academic medical centers. To achieve the last goal of what the learners do once they get the information, we need to start with more role models at the bedside. It is great to read all about it, but when the students get from the basic sciences into the clinics, if these problems are not pointed out when they see an elderly patient, if elderly patients are given just five-minute attention on rounds and the next hour-and-a-half is spent on esoteric issues, the students will not get the message that elder mistreatment is important.

The second thing is we talked a lot about interdisciplinary teams. We need to study those. We need to look at the outcomes so that we can tell other individuals that they should adopt this. The last is that we have to teach physicians to work with more than nurses and social workers. We need to teach them to work with Adult Protective Service specialists, to work with law enforcement, to work with the law schools and the dentists and other people who would be useful beyond just those you see in a hospital.

And so, those are three goals that are achievable. Clearly, there may be policy changes that can be accomplished through this conference, but even just having us here, Ms. Reno, will raise the level of attention, given our respective organizations. The school and I thank you.

ATTORNEY GENERAL RENO: Let me suggest something, just being a devil's advocate for a moment, and I hope I am wrong. Judging by the difficulty we used to have in getting forensic specialists in at the right treatment center, particularly pediatric rape treatment specialists, it was extremely difficult, and that was an area that had heightened public attention.

I think one of the reasons this area is neglected is because too many people are indifferent to aging. But if they could see what could be done, both in prevention and in preserving life and preserving it in a happy way or a comfortable way or a pleasing way so that the person still has fun, I think you can go a long way towards doing it.

So, I think the first step we need to take is to tie it in together, to show what prevention and the delivery of services and expectations can do to make older years happy, fun. I am motivated a great deal in this idea by my mother, who said she was dying and that was it and she was not going to have any fuss about it, and she was perfectly happy. I thought I could make her happier, so I took her up the St. John's River in a houseboat, across Canada in a train and on a cruise, and she had a blast.

That was rather an extreme way to do it, but I think —

[Laughter.]

ATTORNEY GENERAL RENO: I think that there are ways that we can teach ourselves how to make a lot better use of older years. I also watched some of them teach their grandsons how to use

computers, because the sons don't know how to use computers. So, that would be my first step, to let people know that this, including deans of medical schools and the like.

Secondly, this may be heresy, forgive me, but a friend of mine said that he, when I suggested a community advocate as a place where somebody could perform services that a lawyer is expected to perform, but perform them at much less cost and be more effective and make the justice system more effective, the president of the ABA said, "I would have violently opposed you until I went to Ethiopia and saw a man with no more than a high school education saving people's eyesight because he had the wonderful hands of a surgeon.

If we can't get people trained otherwise, is there — can we develop specialties short of a full medical degree that helps in this area, that makes them specialists?

The third is there is a tremendous amount of idealism in America today. They don't want to go into politics. They don't want to seek elective office, but they want to do something that can make a difference. And touchingly, I find a significant number want to go into work with the elderly, and I think we can plumb that idealism and make a tremendous difference there.

Your comments about interagency are so important. We have finally gotten Healthy Children, Safe Schools grant that combines HHS, Justice, Labor and Education. If we can develop those models and talk about continuing education for the elderly, and just the expectation, we can do so much, but I am also very interested in your work at Baylor and how we reach out. So, just put a footnote on this for another conversation about how we train a community police officer to be able to intervene and to identify the signs.

DR. MOSQUEDA: Well, in that case, maybe we will go to Randy Thomas, who is a community police officer or represents that group.

MR. THOMAS: Actually, I'm the one who gets to train the community police officers. Actually, it is a very doable task. I think first, though, you have to convince the leadership that it is an important task and you can train and we have discussed this both on the breaks and in here.

Most of our police officers are, to some degree, motivated by idealism and they really do want to do a good job. They want to help. You have to give them the tools to do it and you have to balance that with other things they need to know, as well. I think the issues we face now in law enforcement are balancing drug issues with violence issues with child abuse with elder abuse with spousal abuse and making them sort of experts at all.

And that is very true of community police officers, and a lot of that is just devoting the training resources to do it. It is an entirely possible task. I think some emphasis from the Department of Justice in terms of program areas, looking at that as sort of a top-down, this is important to us, would help.

ATTORNEY GENERAL RENO: Let me ask you all, you raised the issue about interdisciplinary efforts. In the child abuse area, we saw some marvelous instances of what happened when the detectives sat down with the forensics, "Hey, wait a minute, it couldn't have happened that way."

"Well, what should I be looking for?"

"This, this, and this."

There were some cases that were more obvious than others, but if you get a team that works together and can just appreciate the role that each plays, we can make a big difference.

MR. THOMAS: I'm a strong advocate of MDTs for two very primary reasons: One, it allows the police officers access to expertise they wouldn't otherwise have; and, second, it is a huge educational process as you sit across the table from people you get to know very well and you start to exchange ideas and learn from each other. Very often, the social service providers and the medical community don't understand how law enforcement works. It's not like Cops.

You know, they see what they see on TV, and sometimes practice is not the same thing. So, I would advocate MDTs in almost every case you can do it. I think the discussion becomes how do you focus them? How big do they become? Are they intake-focused or long-term? Those are issues you can deal with, depending on the community.

ATTORNEY GENERAL RENO: Part of it depends on the people, too, because I have been spoiled most of my life by having a medical examiner that was half Sherlock Holmes and half a forensic pathologist. When the two disciplines can talk to each other and understand each other, it makes a tremendous difference.

DR. MOSQUEDA: Maybe this would be a good chance for Patti McFeeley, who is a forensic pathologist, to chime in.

DR. McFEELEY: Well, you probably know more about — having dealt with Joe Davis, who was certainly a giant in our field. But I think one of those is that we really do think that a forensic pathologist and other forensic experts should be a primary person on those review teams, the multidisciplinary team, and in the same model as a child fatality review team or a child abuse team in a multidisciplinary team, because I think we can add areas of pattern recognition, the idea of severity of injuries, that add another dimension to it, in addition to being the people that are not afraid to go to court and are not afraid to interact with the legal system.

So, that is, I think, today — maybe one of the things that has happened is that people have said, "Well, maybe we don't just have to deal with dead people. We can actually deal with the live people." And I think we certainly have a lot of issues in the older people that die, how we could interact and help prevent some of those.

ATTORNEY GENERAL RENO: I used to tell Dr. Davis I just wish that his office handled non-fatalities, as well, because it made such a difference just to get his perspective.

DR. McFEELEY: And I think most forensic pathologists are starting to do some of that. They have done it in child abuse and they are available as a consultant and part of the team, and I think they can add some more to it there.

ATTORNEY GENERAL RENO: One of the things I think is important, since the courts have become the gatekeepers for science, I think they are developing more and more appreciation of how important it is to have a good pathologist, and I keep wondering whether the Justice Department could do something in terms of court work with the Conference of State Chief Justices to suggest more rigorous attention to not imposing on the pathologist unnecessarily.

You might be thinking of how — those of you who testify on any sort of a regular basis, if you could draw up a protocol or a model process or procedure for respecting the rights of the testifying pathologist.

[Laughter.]

DR. MOSQUEDA: We might turn to our token pediatrician in the group here, Wendy Wright, who is at Children's Hospital in San Diego. She and I have done trainings together because she has an expert in the forensic sciences and work in child abuse, and really very few of us in geriatrics do. So, she has been an invaluable resource.

DR. WRIGHT: I think three years ago, if I would have thought that I would have been sitting at a table with a bunch of people talking about elder abuse, I would have thought I died and had a new life. I started working with Dr. Mosqueda in the area of elder abuse and was actually quite surprised at where the field was.

I spent the first little bit of my time calling the 10 southern California county district attorneys and asking them how they prosecuted their elder abuse, who their experts were and none of them had any experts, in terms of the medical field. The only name that came up was Dr. Mosqueda, and that was in the 10 Southern California counties, and that was just three years ago.

I said, "How do you possibly prosecute your cases without medical experts coming from the child abuse field where we work sort of hand-in-hand?"

And they said sometimes it is quite difficult. So, it was a very eye-opening experience to me, and I had the pleasure to work so far, for the past three years, trying to educate

some geriatricians in the area of sort of forensic sciences. I think the one thing that I have learned most during the past three years is that I really think that we need to increase the regard for elder life, if you will.

You mentioned that already, but I think that we have infant fatality review teams, child fatality review teams. We now have DV fatality review teams, and when you ask someone about an elder fatality, they just roll their eyes and shrug their shoulders and say we would be overwhelmed; we could never possibly review them all. But I think people don't pay attention to older people when they die and why they die, and I think there is somewhat of a disregard for life, if you will, and that it is accepted that you die.

I think we have to change that mind set a little bit if we are going to look into why people die and look at the causes of elder abuse. I do think we need to increase the reporting, too, because I think by increasing reporting, you increase the awareness of the general population. And what happens now is people don't report elder abuse because they don't want to prosecute the perpetrator. It might be a stressed care giver and they don't see any alternative backup plans or any use in reporting, so they do not report.

I think that that does not help the population as a whole appreciate the problem. If we could offer increased options to reporting, increased services, increased funding to programs that were available, I think you would start to see physicians and healthcare practitioners increase their reporting, knowing that something might happen.

Thirdly, I think one of the areas that I think child abuse has finally figured out, that elder abuse might take advantage of, is that collaboration has become much more easy with the Internet and with telemedicine. And we have list serves with physicians and we get together and talk on the Internet, if you will, about common problems.

And that has led to very many pilot programs and studies on different medical topics that might not have ever come to pass had we not had that easy conversation. There is also the ability to share pictures on the Internet in a protected way so that if you have a difficult case and you don't feel like you have expertise, you can show someone else your pictures and say, "What do you think?" That leads to increased confidence in what you're looking at and again spurs thoughts about increased research projects and different directions to go.

ATTORNEY GENERAL RENO: I think you have confirmed again what I believed. This is not going to be handled by one effort, in terms of either identifying the markers of abuse. One of my favorite books is the two ladies that were left on the ice by the native Canadian group and how they outwitted everybody. We can really do so much, and I think we're going to be doing further work in this month on the issue of prevention and the like.

But, what has been done with the AARP? Have they been at all involved?

DR. MOSQUEDA: We might actually even turn to Dr. Eisdorfer for a moment, because your pal echoed, I think, some the comments that you were bringing up in terms of the need for a national agenda and involving groups such as AARP.

DR. EISDORFER: A great pleasure to see you again.

ATTORNEY GENERAL RENO: Thank you, Doctor. Thank you for bringing us all here.

DR. EISDORFER: The topic I'd like to address very briefly, as briefly as I can address anything, is I think that we're going to talk about the need for resources clearly in research and training, in integration and so on. But I'm a great believer, as I believe you are, in the wisdom of the American public, the next election notwithstanding.

It seems to me that the role of the Attorney General can be enormously powerful, and someone used the phrase bully pulpit, in putting the case to the American people. We have got a problem and it is a problem that has been largely hidden. We dislike talking about abuse within the family. We had a lot of trouble dealing with child abuse, and now we have another very intimate problem, namely the abuse of our elders.

I think putting that through the media, television — actually, in the case of Dade County, a lot of radio is used, particularly by older people — but various programs, it's important. I would like to see a conference like this, with heads of major foundations in the United States. I could name some, but you can use an economic cut-off. Every foundation with more than \$50 million or \$100 million in resources, which, by the way, has to spend it anyway, could be brought to the fore and say, "Gee, if you're interested in human services or health or economics, all of these issues are involved in the pattern of mistreatment of elderly, physical abuse, emotional abuse, neglect and so on."

So, raising the awareness and creating a national agenda to give us the will — and I am convinced that the federal government, which typically follows the will of the people, and the agencies, which also typically follow the will of the people, will respond and I think the result would be that a meeting like this would be magnified many-fold. And the implications, of course, are that we can then put the awareness and concern into action.

And so, I think leadership is the answer to question.

ATTORNEY GENERAL RENO: You have got a title for another three months, and then you have got tremendous energies and desire to pursue the issue after that. I am looking for appropriate fora and

appropriate opportunities to address the issue and to use whatever collective wisdom I can, including data that provide, to make this issue real.

But what is so important is to be able to show the American people that we can avoid the abusive situations, we can make older years more enjoyable and more productive, and here are some examples of what we're doing. Some of the articles I have seen of your work and others, in terms of going out and finding a hellish situation that can be made better. It does not have to be, because there is almost, I sense, sometimes a hopelessness on the part of the people that either neglect the elderly because they are afraid to come see them again or just snap at it because it seems so frustrating and it is the one thing in their life that they have not been able to control or to see somebody that they love control.

If we can show some successes, I think that is vitally important.

MS. CONNOLLY: Dr. Mosqueda, why don't you share with the Attorney General your idea for these mobile to work with older patients?

DR. MOSQUEDA: Well, I and my team at UC-Irvine have been studying child abuse and domestic violence models and seeing what we can take and apply it to elder abuse, and we are actually in the process of applying for a grant right now to set up sort of a forensic center somewhat modeled after those other areas.

But one of the important differences that many of us here recognize is that we really need to be in the community. We need to be doing house calls, because seeing somebody in the office does not give me nearly the idea, especially if we're looking at issues related to abuse and neglect, than seeing somebody at home. There is just a world of difference.

People might get cleaned up to come to the office, behave differently in the office. So, our big emphasis, particularly myself and the psychologist I work with, is to go to the homes. And what we would eventually like to do is actually develop a mobile unit for assessment kinds of purposes that we hope would then be helpful if we get to level where we know how to do things like forensic interviews, which we don't yet know how to do.

ATTORNEY GENERAL RENO: There is something that is happening in the criminal justice system that is exciting, and that is the concept of community justice. As with all new ideas that have new labels, they can quickly become what is now the latest thing in the criminal justice system. It can become the old JP system of 30 or 40 years ago and not be as effective. But community justice is so important now, and to give people the sense that they are something other than a number and a case in the courts.

And the courts are becoming far more effective, recognizing that if they try to limit their case load and provide resources, they can be much more effective. I think we expect to get some community justice monies, we hope some community prosecution monies, and I think it would be fascinating, Jean, to tie in the concept of community outreach for the elderly.

You could work through community policing. They could be the front line in terms of the eyes and ears. Here is a problem. Let's bring in the team. It could make the mobile team far more effective. We will follow up on that.

DR. MOSQUEDA: I think that this is sort of a good chance to turn to some of the research issues, because one thing all of us struggle with is it is great to set these things up, but how do we know if

they work, a rather basic question, and I was going to turn first to Dr. Pillemer to talk a little bit about research.

DR. PILLEMER: Thanks. At the risk of repeating everyone else, I would like to thank you, too. This has been a wonderful opportunity, and I think wonderful in a way, because it is a disparate group, but it is a group that I think had considerable consensus around research needs and what some of our next steps ought to be.

I think if there's a tension here, it is a tension that results from the gap between what we know right now and the need of criminal justice professionals and health professionals to do their daily work and really take action, but without the kind of knowledge base that we all know we need. Let me say I think there was consensus, too, not only on how much research was needed, but what we ought to try to do.

I think, too, at least in my opinion, and I think it is shared, this is one area where research is not sort of an expensive luxury, but really is a life-and-death matter. The reason I believe that, as you mentioned on the prevention, and clearly to prevent abuse, we need to know the risk factors for it, which are not clearly established right now.

To treat abuse, we need to know what works and for whom and how it works, and we are lagging behind there. We need to know really how much elder abuse there is or what the prevalence and incidence is so we can know what the appropriate amount of resources are to devote to it. And we heard some interesting research, but we certainly need more on the cost of elder abuse, not just the personal costs, which are pretty obvious, but also the economic costs and the healthcare costs.

I think, however, we didn't just lament and complain about the gaps in our research knowledge. I think there it was also some consensus on the things that need to be done. Let me just say very briefly I am sure you would be shocked if someone else said that a group like this would not come up with the perception of the need for funding, and I think that is true.

I think perhaps more important than sheer dollars, though, is the sentiment that this truly is a multidisciplinary problem. In the same way that individual cases have multiple causes, the solutions have to come from multiple sources and that research funding needs to come from multiple agencies and collaborations, and I'm sure that Sid Stahl can say more about that.

I think an issue that has been touched on is public relations, that somehow this issue, after its years of kind of languishing, needs to get moved up, both on the public agenda, but also on the research agenda. And that is certainly something NIJ, I think, and you personally could help with. The focus on program evaluation is critical, and I think everyone agrees that we need to devote increased resources to truly refining the technology by which we intervene in these cases.

Finally, I think that we would probably all agree to an unusual extent that research needs to be driven in this case by real practice needs, that the research have as much to learn from the practitioners as vice-versa, in terms of establishing an agenda and figuring out our priorities.

I think I will stop there.

ATTORNEY GENERAL RENO: One of the things that has troubled me — one of the first summer jobs I had was in the Dade County Welfare Department, and we had to interview and take care of all of the indigent persons in the county nursing homes and the private homes. And it was so interesting, and I have seen it since, a person who seems to be slipping away both mentally and physically sees a new doctor, and there is a better understanding, the medication is changed, and suddenly the

person is — and I am haunted sometimes by how many people are living in a Never-Never Land that could be still productive.

Are we teaching enough in terms of gerontology itself, in medication and the like? I realize that it is not just the elderly that are impacted that way, but I have just seen so many dramatic turnarounds that you just — they seem little short of a miracle. And they're not a miracle. They're some — what about medication and better understanding of medication?

DR. MOSQUEDA: Maybe I'll ask Dr. Lachs to answer that a little bit as a clinician, and also talk a little bit about the research agenda.

DR. LACHS: Thank you for that great advertising for geriatric medicine. One of the areas of expertise that I think geriatricians bring to the care of the elder adult is this notion of polypharmacy — you've been living in an environment where if an older patient or a younger patient, for that matter, if they leave the doctor's office without a prescription, in some ways they feel as if they perhaps have been ripped off.

Given the pressures of the clock and the pressures of medical practice, it takes a long time to describe to someone why medication really isn't indicated in this situation. So, frequently these days I find myself writing on prescription pads things like do deep knee bends or to sort of be thoughtful and not prescribe. I think most geriatricians would tell you that they stop many more medications than they start.

So, I would agree with you that polypharmacy could be an indicator of mistreatment. Some of us have found older adults who are confused and did toxicology screenings of the type we might do for younger people and found a daughter's valium, whereas we would not have expected that, and I guess that would be considered a form of chemical restraint in most situations. So, I think that is a legitimate issue.

I'm so tempted to touch on something you mentioned earlier, Ms. Reno, about the role of community advocates, if not physicians, in this problem. And let me argue that those community advocates could come from our older population. In my own practice, I have a number of people who retired at 65 because they were made to. That is insane. Sixty-five is the neonatal unit where I work.

[Laughter.]

DR. LACHS: And people at the height of their intellectual prowess are losing purpose, where they could be making active contributions as community advocates, as survivors of mistreatment, perhaps, to tell their stories the way younger victims of spousal assault have done. So, I would simply argue that there is an enormous untapped resource of older adults who could serve in this capacity, and we should think about that.

ATTORNEY GENERAL RENO: I really urge you to, because, in addition, they have a thirst for knowledge and they would go back to school and learn some things if you thought — I mean, it is amazing to watch them. One of the things I would be interested in, I think some of the problems arise that one may think is abuse or you don't know the signs, but the family physician, who is not well-trained in geriatrics, makes the wrong medication — prescribes the wrong medication or too much medication or something.

Is there something we can do with the more generalized practitioners to better educate them in terms of abuse, neglect and the like?

DR. LACHS: There will never be enough geriatricians. I testified in front of a congressional committee a couple of years ago about the appalling lack of people who do what we do. And so, our role as educators of physicians — you know, rank-and-file of older adults in nursing homes in the community are not cared for by geriatricians. They're cared for by family practitioners, general internists.

So, our role in educating other physicians about geriatric syndromes — and there are only about 100 articles that suggest that, in primary care practice, physicians miss incontinence, dementia, falling and, guess what, elder abuse, because if you're not falling or beaten in the office, in this hurried medical environment, you know, it's going to get missed.

So, part of the research agenda involves a screening hierarchy, and we talked a little bit about the false positives and false negatives that occur in geriatrics. It is a much bigger problem for elder abuse than in child abuse, we think, because of the higher prevalence of chronic disease.

So, part of this CME, continuing medical education, agenda involves teaching the harried practitioner about how to do what we do.

DR. MOSQUEDA: I thought next we could hear from Dr. Sid Stahl from the NIA, as we wrap up the research part of our discussion.

DR. STAHL: I would just like to amplify what Dr. Pillemer has said, and the group felt that we knew desperately little, in terms of scientific evidence, about elder abuse and neglect. We run the risk of doing as much harm as we do good in trying to solve some of the problems that we see in the community. To that end, NIH has just agreed to fund the National Academy of Sciences, which is the premier independent research organization in the United States to examine what we know and what we do not know about elder abuse and help establish a national research agenda on elder abuse and neglect.

And NIA will, in turn, fund a series of initiatives on elder abuse and neglect. And here is the pitch that I think Laura said before: you can't do it without money. The research in this area will really require, and I think the group agreed with this, more than one federal agency to cooperate in getting this agenda that the National Academy of Sciences recommends off the ground.

I think that DOJ's interest in this forensic expertise and this need for knowledge in this area is one motivator for getting DOJ involved. And certainly, NIA's scientific expertise and our mission for improving the health of older citizens is our role in getting this initiative off the ground. So, I think the group felt that there was a need for some form of joint funding for research agendas on this issue in the states.

ATTORNEY GENERAL RENO: We will follow up, then. We will follow up with you and see, after we find out what Congress does to our budget.

DR. STAHL: If you know before we do, please let us know.

ATTORNEY GENERAL RENO: You all are holding it up, I think.

[Laughter.]

DR. STAHL: It is time to go home.

[Laughter.]

DR. MOSQUEDA: Next, I thought we could hear from Dr. Catherine Hawes.

DR. HAWES: Well, thank you very much. One of the things you said particularly struck me, and that was three more months in this office. I would like to urge you to institutionalize the kind of interaction that we have seen here and with the state task forces, and to have a permanent task force on elder justice at the Department of Justice.

Those of us who are political scientists recognize that this is an issue that waxes and wanes on the public attention cycle, and I think having a permanent task force that brings together people, that keeps the focus, that keeps agencies focused on this issue, would be really helpful toward coming up with solutions, you know, preferably in my lifetime.

I think the other thing is we were asked what we would do now, having sat as individuals at this conference, what would we go home and do, not tomorrow, but maybe next week. And one of the things that I'm going to do at the School of Rural Public Health at Texas A&M is recognize that this is a public health issue, that our commitment is to prevention, and identify ways in which we can address issues of elder abuse.

The Office of Rural Health Policy at HRSA has funded six rural health research centers around the country, and they have asked one of us, Texas A&M, to pick a handful of objectives from Healthy People 2010 that are appropriate for and relevant to rural areas and to identify who the stakeholders are, what the objectives are, and what best practices are that local communities could adopt to achieve the Healthy People 2010 objectives.

And I think that we will identify prevention of abuse and neglect as one of those objectives and bring to bear the work of people in this room and others on how to prevent abuse before it occurs and how to address it when it does.

ATTORNEY GENERAL RENO: What would be extremely helpful to me along those lines is best practices and what is working now. I have the experience of being one of five people who started the Miami Drug Court in 1987, and we started it based on common sense. But we were smart enough to get it evaluated quickly and it fortunately had a good evaluation and there are now over 400, and they require constant attention.

But the public health side of it and the marvelous partnerships that can be formed between the public health side and the criminal justice side are pretty remarkable in the whole area of prevention. I mean, it is remarkable. But, the more you can give me specifics of what is working, that really attracts attention. People start going to see what is working. They go back to their community. They develop a model there. It varies according to the circumstances of that particular area, but it can make a tremendous difference.

So, as you identify things that are working around the country throughout all of this, both prevention, intervention, enforcement and after-care, treatment of the perpetrator, which is something we have not touched on, which I think is critical.

DR. MOSQUEDA: I think I would also like to just ask Dr. Rosalie Wolf sort of this national perspective — we are really honored to have here. She is really one of the leaders and founders and pushers in the area of elder abuse.

DR. WOLF: First of all, it is a privilege to be here. I also want to emphasize the fact that this issue should be highlighted on the public agenda. I know it has been said before, but I think it began

because a few congressmen — and I could say Claude Pepper, particularly, from Florida, made it an issue on the national agenda. We need that kind of attention now to really carry it forward.

ATTORNEY GENERAL RENO: There is no substitute for Claude Pepper.

"Dr. Wolf, how are you today?"

[Laughter.]

DR. WOLF: I also want to reiterate what Mark Lachs referred to, and that is the involvement of seniors. It wasn't spoken of today, but I know that in Canada, the national organization on public awareness and public education involves a combination of older people and professionals. They made a real conscious effort to involve older people who have a stake in this problem. We have not done that. It has been pretty much a professional approach, and I think it is time we give some thought to it.

I don't want to repeat about the need for research, because much of what we have done lacks empirical evidence. Personally, I was very interested in the attention given to the fact that very few death certificate ever include elder abuse, maybe none, but very few. There is a need to raise the index of suspicion among physicians, medical examiners criminal justice personnel.

This will require cross-training and collaboration, but also more knowledge about risk factors. One very specific recommendation was to have a repository for information, for best practices, for training curricula, and people who could serve as expert witnesses.

I want to suggest that there is the National Center on Elder Abuse, sponsored by the Administration on Aging. And I think that a wonderful collaboration would be the Department of Justice and the Administration on Aging, to develop this aspect of the national centers repository.

Again, a consistent theme was the need for resources, not only, by the way, for research, but for the time spent by physicians, criminal justice professionals and others to serve on these multidisciplinary teams.

ATTORNEY GENERAL RENO: You have touched on something near and dear to my heart. We had a session on diversity the other day and talked about typical diversity, and then I said one of the things I'm doing is going home and start including in my meetings on elder justice older people, and I think that is vital, because they have such insight and we must make sure that we do. But wasn't Claude Pepper wonderful?

DR. WOLF: Yes, he was. He was.

ATTORNEY GENERAL RENO: Claude — the first time I ever really paid attention to a political race was when George Smathers beat Claude Pepper, and I thought it was the most unjust thing that I had ever heard. And to have Claude Pepper come back and to be able to serve with him when I served as state attorney was just perfect justice.

DR. MOSQUEDA: Well, you're right. We didn't address issues of perpetrators too much today because I think we were focusing a lot of victims. You'll be interested to know my very sophisticated take on perpetrators, as I've told M.T., is that there are good-guy perpetrators and bad-guy perpetrators, which is — that is about as sophisticated I, as a physician, can get.

But I do think that there really are categories of — and we can throw this open for discussion, perhaps — of people where going through the criminal justice system is not the right answer.

ATTORNEY GENERAL RENO: It is not the right answer. There has got to be something done, because if you let them go, they will slip on, they will have two drinks, just out of their frustration, and they will get into further trouble. But what I am thinking of is you can learn so much from somebody that is expert in the nursing care of an elderly person, how to make them far more comfortable, how to adjust things, little-bitty things that make such a tremendous difference.

And if there was a service, a 24-hour hotline or something that people could call, or the idea of the Internet and how we could create something there just that would make it immediately accessible to everybody, the frustration that people go through in trying to find out the services and not knowing whether they are doing it right is — I think sets them up sometimes to make mistakes.

The advice for the potential perpetrator who is, at the moment, the loving care giver could be tremendously important.

MS. CONNOLLY: Laura, perhaps you could describe for the Attorney General and for your colleagues around the table — some of the kinds of interventions that you think do work for the good-guy perpetrators.

DR. MOSQUEDA: We might have Dr. Pillemer talk about this a little bit, too, in terms of some of the research you have done just on asking people who are care givers of folks with dementia. It is certainly a technique I use in my clinical practice. Do you want to expand on that a little bit?

DR. PILLEMER: Sure, and also I think would hark back — we have talked a whole lot in here about things we don't know, and I think that we do know some good best practices. I guess that is redundant, good best practices, but we know some best practices which, I think, really do seem to work, and one of those is multidisciplinary teams that we have talked about.

I mean, I absolutely agree with your notion of good-guy and bad-guy perpetrators, and if there is anything, I think, that we know about elder abuse now, it is just not a monolithic phenomenon. It has different types and different ways it occurs. I think there is a clear division between stressed care givers, people who are really doing their best and making their best of a bad situation.

I think Greg Paveza has studied this, too, among Alzheimer's care givers, where it's people who are really trying to do their best and just are stressed beyond sort of normal limits. And, for them, I think the whole range of care giver support programs like you have just — and you mentioned a couple, hotlines, other kinds of issues, the range of support groups, that now we're getting some information on their effectiveness. And I think we need a different set of things for the bad-guy perpetrators, who are people who are exploiting elderly people, who are —

ATTORNEY GENERAL RENO: I've got those guys.

DR. PILLEMER: We'll let you handle them.

ATTORNEY GENERAL RENO: But that is where we come back. I mean, I couldn't agree with you more. We have got to focus on those cases. Mr. Hoffman, I'd be interested in your assessment. I think there are going to be situations where there is financial exploitation that results in terrible neglect and otherwise, and we are going to have to sharpen our capacity to deal with that.

MR. HOFFMAN: Absolutely. We stayed away from financial exploitation, but usually elder abuse is not just about one discrete event, you know — have it linked with financial exploitation leading to neglect or leading to abuse. So, it is certainly part of the big picture. In an institutional setting, where the cases I have been involved with, thankfully, with your support, it is of great concern, the issue of federal funds going into long-term care facilities and the care that is being rendered in such a grossly negligent fashion that you have some really unspeakable harm occurring to residents.

And that is an area I think we all agree is appropriate for law enforcement involvement, and not only at the federal level, but at all levels. And it is something that, I think, needs to be continued to be advocated for. But you're absolutely correct, the financial side of things may just be the tip of the iceberg, and we have some financial fraud statutes that we can prosecute federally.

ATTORNEY GENERAL RENO: Dr. Eisdorfer?

DR. EISDORFER: I would certainly like to underscore the issue of the nursing home. It is one of the areas where we already have a lot of involvement, and we are dealing with the most dependent, most needy and least vocal person. Often, they are afraid to report for fear of being either further abused or, in fact, being moved out of this place to the unknown.

I certainly think that is something we can do, particularly, you know, we talked briefly, to be specific, about when patients have trauma, they may be sent, not to one, but to one of several emergency rooms. So, one of the things that we need is a reporting mechanism to identify whether there are, in fact, patterns or problems around certain nursing homes. The same patient might end up in four emergency rooms in the same year; it is important to know that patient was in the emergency room four times.

I want to pick up the issue, because the NIA is supporting a national project called, REACH. I love these acronyms. I think they came up with the acronym first and then figured out what it meant, Research to Enhance Alzheimer's Care givers' Health, and this is now the fifth year of a project. Greg and, I guess, Donna Cohen behind me, and I have been looking at Alzheimer's disease and came up with the notion that about more than half of women taking care of husbands or about 40 percent of husbands taking care of wives become clinically depressed, and that is a toxic situation.

The way funding is now, I, as a clinician, get paid for taking care of the patient, but I spend far more time with the depressed spouse, and unless I can convert them to a patient, there is an economic disincentive. I do it, but I just want to put on the record it is a disincentive. That is just plain stupid. There are probably better words for it, but I don't know any.

ATTORNEY GENERAL RENO: Plain stupid sounds — we sometimes say that people haven't committed a crime, but that they should be indicted for fundamental dumbness.

[Laughter.]

DR. EISDORFER: This is an area where we could certainly intervene and come up with a positive approach, rather than merely a prosecutorial approach after the end. Having said that, I'm going to kind of abuse your time for one more second. What I am about to say sounds exactly the opposite of what we have been focusing on. One of the problems, I believe, is that we tend to pathologize aging, and you touched on the instance of your mother, and it really rang a very important tone with me.

We need to remind ourselves that most older people have a marvelous or could have a marvelous quality of life. So, when we pathologized dementia and said all older people are going to be demented, we normalized it and then dementia was not a problem to deal with. We began to say,

"Gee, this is really not normal, and there are a lot of people out there who are not demented," we began to show a contrast and it enabled us as clinicians to be able to say, "Gee, let's look at this thing."

And so, I guess my point is that with all the emphasis on Medicare and Medicaid and abuse, we have to remind ourselves that there is a positive alternative. So, when we see the negative, it is worth being concerned about. This is not the normal state of aging.

ATTORNEY GENERAL RENO: That is the message that has got to be — I mean, so that medical schools will make an investment. Just put it in crass economic terms, so that the little entrepreneur who wants to get into a business will say, "Hey, that is going to be a business, because they really are showing that elderly people can live far more comfortable, productive lives."

I think the other side of the coin, too, is talking about the care giver. You have a particularly delicate balance here, because if you get in the whole area of child abuse, there are a number of people critical of what criminal justice has done because they think they cast too much suspicion on a parent who is only doing their job. Somewhere, I think this could probably be more acute in the elderly — cases of elderly victims. We have got to be very, very careful that we are not big brother watching.

I cannot thank you all enough. This has been extremely helpful. I would ask of you — my telephone number is (202) 514-2002. 514-2002, and if there is any specific idea you have that you would like to share with me, I am very anxious to do as much as I can to get the Department of Justice moving in the right direction on this. And then following up in any way that I can after I go back and walk in the grass in my bare feet for awhile.

Any other ideas? You who work in this area are just extraordinary. I have seen the magic that you can bring to somebody's life that seemed done and over with, and I have seen what you can do in terms of preventing problems, and I would like to work with you in every way I can to let people know that old age can be fine. Thank you.

MS. CONNOLLY: Well, I think we have about ten minutes to wrap up. Maybe one of the things we want to do with our last few minutes is just identify a few priorities that we want to walk out with. Both of you are looking at me blankly.

MR. HOFFMAN: This wasn't scripted.

MS. CONNOLLY: No, it wasn't scripted. This is what happens when I fly solo. Final comments, closure —

DR. MOSQUEDA: My big final comment is how do we keep things going, and I think that is worthy of a few minutes of discussion because this was complicated and expensive and I think already, from my standpoint, totally worthwhile in terms of what I learned. And I think what we can take back again to home institutions and agencies. But, my question for our group is how do we keep moving forward.

DR. SANDERS: I agree with what you're saying completely, and I've been part of groups like this where there is a lot of energy and dust, but nothing — how do you evaluate it a year from now or something like that? One thing would be there is a paper, a monograph that comes out of it, to have an action agenda that may be sent around for people to comment on and then the action agenda has specific, even timelines associated with it. If we say we want to have a consensus conference or a research agenda approved by — and that all follows from there.

MR. HOFFMAN: I think it is also sort of following up with each other as to what is happening in your own experiences, what you are finding and what your own world is all about. So, as opposed to trying to guess what is working or not working or what your findings are, that there is some sort of central repository. And we're also moving towards the computerized approach, how would that work and how do we create this database and what should it look like?

MS. CONNOLLY: One of the things Dr. Wright suggested a couple of times is a list serve. I know that Lori Stiegel of the ABE Elderly Commission has a list serve on elder abuse, but it might be worth having a list serve specifically for elder abuse and neglect forensic issues or medical forensic issues.

MR. THOMAS: The list ought to offer prescriptive thought to — and they basically come out of child abuse. One is I know I've use APRI stuff because you can call them up and a lot of their material on child abuse is excellent, they've got a good history of training. The second is our law school at the University of South Carolina created what they call the Children's Law Center. It deals with both delinquency and child abuse and neglect. It is staffed with interns — actually a retired family court judge.

This is small scale, but the point is that this is a point of expertise. Our Children's Law Center is great. If you have a child abuse question, I call up and if they can't answer it, they go find somebody who can. Same with APRI. Right now, there's no central point that I can just reach for a telephone that has a national reputation, looks across the board — I guess I keep coming back APRI, it might be the best example of how to go about doing that.

DR. WRIGHT: The National District Attorney Association here who has APRI underneath it and they're going to take someone from both DV and child abuse, and perhaps look at forming their own elder abuse unit within APRI.

MR. THOMAS: The real advantage is that right now we're going to take material that APRI has developed, basically in turn, give it to our Children's Law Center — that is going to become our text book and training material for our two-week child abuse investigators course. So we have a standard that meets a national standard, and I just can't tell you how important that is, particularly for the medical stuff.

I need that sort of that handy handbook I can open up as a police officer and say, yes, that is an indicator of abuse.

MS. CONNOLLY: Catherine?

DR. HAWES: I think we had suggested there be a computerized database of people that we know who either have served or are willing to serve as expert witnesses, or are willing to help people during the investigation phase. And I think that would be a concrete next step that people could do. The other thing that would help me as a researcher, really, is to have short descriptions of projects that people have done that are relevant in the area, or of projects that they know about, research studies they know about or programs that ought to be evaluated. I mean, that is something that we could all just send you by e-mail if somebody would remind us.

MS. CONNOLLY: Dr. McFeeley?

DR. MCFEELEY: Yes, on the short term, I was thinking on the same line, if most of the people here have e-mail and you have us all on a list, which I'm sure somebody does because they kept sending us all of this. But if just at least on the short-term, if you want comments back on this or other ideas, you know, to go into your final report. I think it would be very important to have a report

come out from this — a consensus report. That would be very helpful to e-mail everybody and let them respond. And, then it could also serve as a kind of a nexus for beginning a group for letting us know that information would be, whether it is a list serve or something, but it would be really helpful to keep in touch in the really short-term just by e-mail.

MS. CONNOLLY: Dr. Pillemer, before he left, had a similar type of suggestion. As he mentioned, he hates meetings that spawn other meetings. But in this case he recommended that it probably made sense to try and hold on to the momentum and stay in touch in some way.

DR. DYER: Perhaps what we could do, as we talked about so many things today, is each go home and come up with a list of action items and then maybe somebody here can collate them and we can follow up those action items next visit and see how what we decided today was played out.

MS. CONNOLLY: Whether we heard the same action items and the same conversation — Catherine?

DR. HAWES: I think another thing that we could do — I think there are two. One is I think you ought to have a meeting like this that focuses on the research needs and that involves the CDC, ASPI, HCFA, AHRQ, AOA, you know, sort of the major funding agencies, so they can make this part of their research agenda.

The second thing just went right out of my mind.

MS. CONNOLLY: We did try to invite them. What about private funding sources?

DR. HAWES: My experience with foundations — I've been looking for money on nursing home regulation and quality assurance for a long time. Karl may have, like, better sway with them than I do. They just don't think it's very sexy. It's not nice stuff. They like nice stuff. Now, Archstone seems to be one of the counterexamples, so I mean it is certainly worth asking. There is a Grant-makers In Health group here in D.C. It is worth talking to them and seeing if they would be willing to sponsor something like this conference.

MR. HOFFMAN: For those who have remained throughout the whole day, as a reward, is there anything you that you would like to ask or any suggestions for anyone who has been an observer all day? Just state your name and —

MS. CORTRIGHT: Maryellen Cortright from the Archstone Foundation. I would like to suggest that in addition to Grant-makers In Health that I'm an active member of, there's also a group called Grant-makers In Aging that just met last week. It is a much smaller group, only about 150 foundations around the country that are focused primarily on aging, but to talk to those groups about the co-sponsoring something on the slide might be very valuable.

MS. CONNOLLY: Anyone else?

DR. STAHL: That would be very useful, that suggestion that you had from Archstone. I've tried very hard to get people in other agencies, like AHRQ, who is sponsoring part of the NAS panel and several other agencies to no avail. And I'm not sure if my timing was poor or my solicitation was poor, but it would be extremely helpful if there was pressure, if you will, or at least a suggestion from outside agencies that several of the other funding agencies get involved in at least the outcome of the NAS panel. Because the NAS panel is really just the beginning before we begin putting together initiatives, research initiatives on elder abuse and neglect.

MS. BURGESS: If Janet Reno asked Secretary Shalala, probably they would come.

MS. IVANSIC: My name is Joanne Ivansic and I'm with the Senate Special Committee On Aging and I wanted to second the stuff that Catherine Hawes has said, that I think there needs to be an institutionalization somehow of this, at the Department of Justice. M.T. has done such a great job of organizing this and the other conferences that have happened over the past year or two that have made all this possible and have raised the consciousness. I think that's really good.

MS. CONNOLLY: I didn't pay her, I swear.

MS. COLEMAN: And we all feel that way M.T. I'm Nancy Coleman. I'm with the American Bar Association and most days I work for Laurie Stiegel, but — at least in this area I do.

I think that — I found today to be extraordinarily stimulating and I found it to be stimulating in the sense that — and I said to a couple of people, it really wasn't Claude Pepper who first had the first hearing on elder abuse, but rather Morio Biagi was the leader in 1978 and '79 when he held his hearings.

But, rather I think the question is how do we look today at what we're doing? One of the things I saw as people were speaking earlier was the real nature of having cross-disciplinary efforts at the graduate level, whether it be social work, nursing, medical school, law school. And I certainly have seen over the years attempts to have elder law clinics in the medical schools. I've seen a number of other efforts like that and it seems to me that the challenge for you on academic campuses is to see whether or not cross-disciplinary training programs can be developed, and whether or not there is either Department of Education money, and we haven't talked about that, or HCFA money to start some of these things. But that we really look strategically at it, not just in terms of elder law issues and end of life issues, but at the maltreatment, elder abuse kinds of questions that we've been talking about today.

At the University of Oklahoma, the University of Michigan, there are cross-disciplinary seminars of medical students, law students, social work students, nursing students and other allied professionals. Why can't that be true in this area, as well? And why can't we begin to look at, as I think Dr. Lindbloom asked earlier, some of the research agendas that really are and can be developed out of some of those clinical settings as we begin to look at it. I think we can document some of the issues again as we see them.

MS. CONNOLLY: One of the things that raises for me also is that we have heard a lot about how effective multidisciplinary efforts are, at sort of a grassroots level. We have to employ that same multidisciplinary approach at a national policy-making level in setting an agenda that makes sense. Obviously this discussion is a creature of that sort, but we want to make sure that it continues.

DR. GAMBRELL: I think something that would be helpful as an action plan is to get together both of the multidisciplinary teams, in other words, have some input as to which of these teams people are working on and working well, because I think that's one thing that everybody agreed was a very positive step, the utilization of those teams. We're putting one together, I know, in my state and we've heard about several others, but it would be good on the list served to have some listing of that where people have some interaction with them so that we can communicate directly with them as we're putting other ones together, because I think it was real consensus out of the group.

MS. COHEN: I'm Donna Cohen from the University of South Florida. Listening to the themes around the table, which are many, and also listening to what Janet Reno said, I think one of the action points is to determine a way to identify best practices that are integrated best practices and as an example — I'm sorry Greg Paveza didn't bring it up. Mrs. Reno referred to the drug court which she set up many, many years ago. Hillsboro County, Florida established the very first elder court that we

know of in the country, which was pooh-poohed by the state Supreme Court because they didn't want specialty courts.

One of the themes that comes here in terms of looking at legal interventions, as well as legal interventions that combine social interventions, is how we can develop best practices that have regional state effects and because the state Supreme Court ruled against it, even though we've got many retired state Supreme Court justices involved and politicians involved. We set up an elder justice center. And it took the leadership of our chief judge, working with many of the judges in the agencies, and instead of actually prosecuting things legally, we actually have a whole social service agency set up within the court system. So, we went around what the state Supreme Court did.

So I think we have many, many best practices that are not represented by people here because you have to start somewhere and think we need to catalog those.

MS. CONNOLLY: Great. Well, we aspire to run on time, not maybe in my personal life, but at least in events that I'm part of. I would like to thank David and Laura for having done just a fabulous job moderating. Putting together a beast like this is no mean feat and they have spent many, many hours, along with many other folks in this room and some of you who have left, and I am very grateful.

I think it is a good beginning. Unfortunately, things in this area tend only to be good beginnings. They never tend to be good ends.

Date Created: October 18, 2000