2006

# The Criminal Justice Response to Elder Abuse in Nursing Homes: A Routine Activities Perspective

Brian K. Payne
*Old Dominion University*, bpayne@odu.edu

Randy R. Gainey
*Old Dominion University*, rgainey@odu.edu



## Original Publication Citation

Payne, B. K., & Gainey, R. R. (2006). The criminal justice response to elder abuse in nursing homes: A routine activities perspective. *Western Criminology Review, 7*(3), 67-81.

WESTERN CRIMINOLOGY REVIEW

*Western Criminology Review 7(3), 67–81 (2006)*

# The Criminal Justice Response to Elder Abuse in Nursing Homes: A Routine Activities Perspective*

Brian K. Payne
*Old Dominion University*

Randy R. Gainey
*Old Dominion University*

**Abstract:** *Politicians and researchers have begun to pay more attention to elder abuse in recent times. Most of the research on elder abuse has focused on cases of abuse perpetrated by family members, treating the phenomenon as a social problem, but it is increasingly being conceptualized as a crime problem. The current study examines elder abuse in nursing homes from a criminological perspective. Using routine activities theory as a guide, particular attention is given to the criminal justice system's response to abusive activities committed by nursing home employees. In all, 801 cases of abuse investigated by Medicaid Fraud Control Units are examined. Results suggest that past research has mischaracterized "the motivated offender" and that legislative policies fall short of providing capable guardianship. In addition, increases in vulnerability are related to abuse type. Implications are provided.*

**Keywords:** elder abuse; routine activities; nursing homes

## Introduction

In the past two decades, scholars have begun to pay more attention to the way crime influences elderly persons. A tendency to dismiss the importance of the crime problem among older victims is, in part, based upon official statistics, such as the Uniform Crime Reports (UCR) and National Crime Victimization Survey (NCVS). These data sources suggest that elderly persons are rarely victimized in comparison to younger persons (Payne, 2000). Relying on official statistics to define the crime problem is misleading (Friedrichs, 1996) and when behaviors outside of these official statistics are considered, the number of older victims increases significantly.

From a criminological perspective, elder abuse can be defined as "any criminal, physical, or emotional harm or unethical taking advantage of that negatively affects the physical, financial, or general well-being of an elderly person" (Payne, Berg, and Byars, 1998: 82). Estimates about the extent of elder abuse range from 500,000 to two million cases a year (Payne, 2000), though it is difficult to determine the precise extent of abuse because of varying definitions of abuse and a lack of reporting (Arnovitz, 2002; McCarthy, 2002). Also, like the UCR and NCVS, these estimates are also flawed, primarily because they often exclude cases of elder abuse occurring in long-term care settings such as nursing homes and adult day care centers. When these other settings are considered, research suggests that abuse in institutions is extensive and alarming. Some studies suggest that between 81 and 93 percent of nurses and nurses' aides have personally seen or heard about abuses in the previous year (Crumb and Jennings, 1998; Mercer, Heacock, and Beck, 1996). Another study found that nearly one-half of nursing homes in Connecticut had at least one incident of abuse reported to the state's ombudsman reporting system over a two-year time span, and nearly 70 percent of the homes had quality-of-care complaints (Allen, Kellett, and Gruman, 2003). Focusing solely on theft in nursing homes, estimates from Harris and Benson (1999) suggest that as many as two million instances of theft may occur in nursing homes in the United States each year.

With more and more individuals requiring some form of long-term care each year, it is prudent that criminologists increase their understanding of cases of abuse occurring in long-term care settings. The current study focuses on cases of patient abuse investigated by fraud control units across the United States. In addition, we develop routine activities as a theory useful for understanding elder abuse in long-term care facilities and developing policy as a guide to prevent elder abuse. We analyze data from Medicaid Fraud Reports to address several research questions developed in the following review of the literature.

*The authors would like to thank anonymous reviewers and the editors for their input, which greatly improved this paper.

**Review of Literature**

Stannard (1973) conducted one of the first studies on patient abuse over three decades ago. Since then, only a handful of sociologists and criminologists have studied elder abuse and even fewer have considered elder abuse in long-term care settings. To be sure, other disciplines such as nursing, legal studies, and gerontology have devoted a significant amount of attention to elder abuse, and these studies have guided the criminological efforts in this area (see Allen et al., 2003; Castledine, 2005; McCarthy, 2002; Northway et al., 2005; Payne, 2005; Shaw, 1998). Studies in these other fields have addressed a number of different issues such as the health consequences of elder abuse, the legal ramifications, and strategies to identify cases of elder abuse. Of the criminological studies conducted on this topic, attention has been given to the dynamics surrounding patient abuse and effective strategies to respond to abuse.

*The Dynamics Surrounding Patient Abuse*

After Stannard's classic study, Pillemer and Moore (1989; 1990) and Pillemer and Bachman (1991) were among the first researchers to empirically examine patient abuse in nursing homes. Both studies relied on data from phone surveys with 577 nursing home professionals employed in Massachusetts. Pillemer and Moore (1989) reported that over one-third of the professionals indicated that they had seen a fellow employee commit an abusive act in the previous year and fully ten percent of the respondents reported that they themselves had been abusive. The activities they reported included hitting or slapping patients, excessive use of restraints, grabbing and shoving patients, and throwing items at patients.

Pillemer and Bachman (1991) focused on the impact of institutional, staff, and situational characteristics. Each of these factors was theoretically linked to elder abuse. *Institutional factors* include the size of the institution, whether the institution was private or public, and the rates charged for the institution's services. While Pillemer and Bachman (1991) found that these factors were not empirically related to patient abuse (defined solely as physical assaults against patients), other research focusing on patient neglect has suggested a relationship between these factors and mistreatment (Jenkins and Braithwaite, 1996). According to research by Shaw (1998) structural factors such as the number of employees, low wages, and types of nursing home policies are related to patient abuse.

*Staff characteristics* are concerned with the characteristics of employees working in nursing homes (Pillemer and Bachman, 1991). These characteristics include age, gender, level of pay, education, occupational position, and attitudes toward patients. Again, Pillemer and Bachman (1991) found minimal effects of these characteristics on assault rates. However, other research by Harris and Benson (1998) found that negative attitudes toward patients and job satisfaction among staff are positively and negatively related to rates of theft in nursing homes, respectively. Further, nurses' aides have been found to be the group implicated most often in cases of financial and physical abuse of patients (Harris and Benson, 1996; Payne and Cikovic, 1995).

According to Pillemer and Moore (1990) and Pillemer and Bachman (1991), situational factors are the strongest predictors of patient abuse. *Situational factors* refer to factors such as the level of conflict, the presence of alcohol use, stress, burnout, and responses to aggression. Results of the interviews with nursing home professionals in both studies by Pillemer and his associates showed that stress, patient conflicts, and patient aggression toward staff were contributing factors to the physical abuse of residents. Regarding stress, the authors suggest that the respondents felt "burned out" because they did not have enough time to perform their expected duties. Patient conflict entailed conflicts over eating habits, hygiene, toileting, and unwillingness to dress.

*Official Response to Patient Abuse*

Initial efforts to control patient abuse entailed policies and laws that tended to keep these cases out of the criminal justice system. The 1976 Older Americans Act resulted in the creation of nursing home ombudsmen programs. The word "ombudsman" is a Swedish word meaning "a public official appointed to investigate citizens" (Administration on Aging, 1998). These programs were designed as a strategy to control abuse and neglect in nursing homes. The programs use paid employees and unpaid volunteers to receive and handle suspected allegations of nursing home abuse (Lachs and Pillemer, 1995; Paton, Huber, and Netting, 1994). In 1997, 880 paid employees and 6,800 certified volunteers handled 191,000 complaints and shared information with 201,000 citizens (Administration on Aging, 1998). The duties of ombudsmen include investigating complaints, reviewing nursing home licenses, and protecting the rights of nursing home residents (Netting et al., 1992; Vladeck and Feuerberg, 1995). Not surprisingly, the presence of ombudsmen is related to increases in complaints of abuse and regulatory penalties from the Department of Health

and the Health Care Financing Administration (Nelson, Huber, and Walter, 1995).

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) has also been instrumental in developing strategies to prevent abuse against nursing home residents. Among other things, the NCCNHR has been influential in increasing awareness about the rights of nursing home residents. For example, the rules guiding the provision of services to elderly persons in nursing homes can be traced to the Nursing Home Reform Law of 1987. The NCCNHR devotes a great deal of effort to ensuring that residents, workers, and citizens are aware of the rights stemming from this law.

By the early 1990s, legislators and policy makers had become concerned with the criminal justice system's minimal response to elder abuse cases. As a result, elder abuse became criminalized through various strategies such as the passage of penalty enhancement statutes, enforcement of mandatory reporting legislation, and increased police officer presence in response to elder abuse and neglect allegations. These changes occurred despite the fact that little or no research had considered the need for the criminalization of elder abuse.

More recently, researchers have considered various issues arising as a result of the criminalization of elder abuse. These issues include police officers' attitudes about elder abuse and neglect and obstacles that police officers face in responding to elder abuse and neglect cases. Research on police officers' attitudes about elder abuse and neglect has focused on their definitions of elder abuse as well as their attitudes about various elder abuse policies. For instance, Payne, Berg, and Byars (1999) surveyed police chiefs from the Commonwealth of Virginia to see how their definitions of elder abuse compared to those offered by social service professionals. Their research found that police chiefs defined the crime from a legal orientation while social service professionals tended to define the crime from a moralistic perspective.

Using the same data set, Payne, Berg, and James (2001) examined how these groups justified punishing elder abusers. They found that justifications varied by abuse type, but that all groups supported rehabilitative ideals at least to a degree. In a more recent study, Payne and Berg (2003) examined how police chiefs (from California, Alabama, New York, and Colorado) and nursing home ombudsmen (from 26 states) viewed the criminalization of elder abuse policies. This more recent study reveals that the groups supported the criminalization policies, but they did not necessarily support stiff penalties for abusers. The authors concluded that police chiefs and ombudsmen do not support a "war on elder abuse."

Research has also considered the obstacles that police officers face when responding to elder abuse and neglect cases. Payne, Berg, and Toussaint (2001) examined the policies 119 police chiefs reported following in elder abuse cases. They found that about a third of the departments had specific elder abuse programs, but problems such as limited funding, inadequate training, communication problems between younger officers and older victims, and family cover-ups hindered investigations. A specific concern noted by the chiefs was that victims' cognitive impairments made it difficult to gather evidence.

Given that elder abuse has become criminalized, and criminal justice involvement in patient abuse has increased, research needs to consider the role of the criminal justice system in responding to patient abuse cases. We find the routine activities approach to be a valuable guide to better understand elder abuse cases that occur in long-term health-care facilities, and to examine the system's response to patient abuse. The following describes the utility of the routine activities perspective in the study of elder abuse.

## Routine Activities and the Victimization of Elderly Persons: Conceptual Framework

The routine activities approach suggests that crime occurs when three elements are present at a given time and in a given situation—a motivated offender, the absence of a capable guardian, and a suitable target (Cohen and Felson, 1979). A *motivated offender* can really be anyone. Marcus Felson (1998:11), a prominent routine activities theorist, states explicitly, "Everybody could do at least some crime at some time." Of course there is considerable variation in criminality across individuals, but there are ample pressures and allures for engaging in various crimes. Furthermore, certain institutions, like nursing homes, may put pressures on citizens who normally would not typically engage crime against in elders but may react negatively in that environment. Furthermore, such institutions may even draw in motivated offenders who want to have power over those weaker than themselves. *Suitable targets* is also a varied category that could be anything the offender is interested in, such as a commodity they want or can sell or trade for something else, or a victim they wish to or can harm. In the case of long-term care settings, the suitable target could be possessions of elderly residents or the residents themselves. Finally, a *capable guardian* can be anyone including the potential victim, a "place manager" such as an orderly or nurse's assistant responsible for maintaining

order and discouraging crime, or a non-human entity such as a locked door or a camera monitor (Eck, 1998).

Official statistics suggest that in comparison to the younger population, the elderly population has an extremely low victimization rate. At first glance, routine activities theory would appear to explain this low victimization rate. After all, the kinds of activities older persons engage in would theoretically place them at less of risk for victimization. Alternatively, in delving into the routine activities of elderly persons, it is reasonable to suggest that their lifestyles place them at risk for certain types of victimization. For example, elderly persons who live alone are more likely to be harmed or even killed during burglaries than are younger persons (Kennedy and Silverman, 1990). Other research suggests that the risk of theft-related homicides for elderly persons is "relatively high because they are more likely than younger persons to lack capable guardians and to be perceived as suitable targets" (Nelsen and Huff-Corzine, 1998:130).

Along similar lines, routine activities theory has been used to explain robbery of older persons. One study finds that those 85 years of age and over are more likely to be robbed at home while other groups are more prone to be robbed while away from the home (Faggiani and Owens, 1999). Some have suggested that older persons confine themselves to their homes in an effort to prevent victimization. Unfortunately, this particular precautionary strategy does not always reduce victimization risk (Miethe, Stafford, and Sloane, 1990).

Studies focusing on the victimization of elderly persons from a routine activities perspective have typically examined the victimization of older persons living in domestic settings (Faggiani and Owens, 1999; Nelsen and Huff-Corzine, 1998). Few studies have used routine activities theory to consider the victimization of a growing segment of the elderly population—those living in long-term care settings. A number of aspects about the long-term care situation seem to parallel ideas from routine activities theory. Focusing specifically on capable guardians, vulnerable targets, and motivated offenders provides a foundation for understanding patient abuse in long-term care facilities.

## Capable Guardians and Patient Abuse

As mentioned previously, potential guardians are generally seen as persons or physical conditions that thwart the potential offender from committing the act. Although routine activities theorists tend to downplay the role of the criminal justice system as capable guardians (see especially Felson, 1998), at least two overlapping components of the criminal justice system may potentially act as capable guardians, albeit indirect guardians, insofar as patient abuse cases are concerned—laws and activity of the criminal justice system. Mandatory reporting laws and penalty enhancement laws are the cornerstone of criminal protections in elder abuse cases. Mandatory reporting laws require certain professionals to report suspected cases of elder abuse to the authorities. Professionals who fail to report suspected cases of elder abuse can be held criminally and/or civilly liable. These laws are criticized on a number of grounds, including suggestions that they are unenforceable, baseless, and ageist (Moskowitz, 1998). Alternatively, penalty enhancement laws call for increased penalties for offenders who victimize elderly persons. Surveys of police chiefs by Payne and Berg (2003) reveal very little support for penalty enhancement statutes, but they have been implemented in a number of states. If mandatory reporting and penalty enhancement laws are not supported by criminal justice professionals, one has to question their utility as capable guardians; however, to date there is little empirical evidence one way or another. From our perspective, to the extent that mandatory reporting laws are covered in basic training of workers in long-term-care settings, they may increase the ability of place managers (such as doctors, nurses and administrators) to act as capable guardians.

Activity of the criminal justice system in patient abuse cases can also be seen as a potential candidate for capable guardianship. Generally, when victims or witnesses decide to involve the justice system in patient abuse cases, either the local police or Medicaid Fraud Control Units (MFCU) are notified. The latter are more commonly used in physical and sexual abuse cases and even when police are first notified they often call the MFCU because they are more familiar elder abuses (Payne and Cikovic, 1995). Medicaid Fraud Control Units are state-authorized agencies generally housed within a state's attorney general's office. They exist to detect, investigate, and prosecute crimes occurring in nursing homes, especially Medicaid fraud and abuse. While traditional reactive policing styles are used, in some situations undercover law enforcement officers have infiltrated nursing homes as workers to investigate whether mistreatment is occurring (Hodge, 1998).

A recent investigation by the United States Government Accounting Office (2002) revealed patient abuse cases are often not prosecuted because of evidentiary problems, trouble with witnesses, and delays in reporting. Thus, not prosecuting "affects [residents'] vulnerability to abuse in that perpetrators perceive them to be less able to report the abuse and therefore have little

fear of retribution" (Petersilia, 2001:684). As Stafford and Warr (1993) persuasively argue, deterrence is affected not only by punishment of the offender, but by avoiding punishment as well. However, the presence of penalty enhancements and especially mandatory reporting laws may be important in that the reporting of an incident may be punishment enough, by shaming the offender and warnings of the possible repercussions.

*Vulnerable Targets and Patient Abuse*

In addition to the justice system's inability to sometimes prosecute cases, two related factors appear to increase the vulnerability of elderly patients—lifestyle and impairments. Lifestyle has long been seen as the central element of routine activities theory, usually focusing on youthful victims who frequent dangerous places that lack capable guardians and put them in close proximity to motivated offenders. Such lifestyles increase individuals' risk of victimization (Lasley, 1989; Miethe et al., 1990). For some nursing home residents, their lifestyle or "routine inactivity" may make them suitable and vulnerable targets for both personal and property crime. For example, shared quarters where other patient's families visit may make personal possessions suitable targets, and being in the care of others puts one at risk of being victimized by the caregiver (Payne and Gainey, 2005). Perhaps more importantly, routine activities theorists have pointed to the role that potential victims can play as capable guardians. For those residents with various physical and cognitive impairments, exposure to possible motivated offenders and the absence of capable guardians may be the norm rather than the exception. Indeed, research shows that those with cognitive disabilities are more likely to be victimized than those without disabilities (Petersilia, 2001).

*Motivated Offenders and Patient Abuse*

Of the limited research that has been done on crimes against nursing home residents, most has painted a picture of poorly paid and inadequately trained staff (Payne and Cikovic, 1995; Harris and Benson, 1998). Employee stress is often offered to explain physical abuse cases especially in dealing with the occasionally aggressive patient (Payne and Cikovic, 1995). For theft cases, low pay along with negative attitudes about older persons have been seen as common qualities of abusive staff (Harris and Benson, 1998; Harris and Benson, 1999). Also, males, minorities, new employees with less experience, and aides have been overrepresented in allegations of abuse (Harris and Benson, 1998; Harris and Benson, 1999; Payne and Cikovic, 1995).

The three elements of routine activities theory work together to increase the victimization risk of nursing home residents. As an illustration of the interconnections among these elements, consider the following comments from Petersilia concerning the risk of victimization among children and adults who are institutionalized because of a developmental disability (2001:673):

> Institutional care may function to both increase the exposure of people with disabilities to potential offenders and may isolate them from sources of protection, such as the police. An offender may choose an individual with a disability as a victim out of a belief that apprehension is less likely and that punishment will be less severe if apprehension occurs.

Although the relationship between routine activities theory and patient abuse can be pieced together hypothetically, no empirical research has used this approach to examine the criminal justice system's response to patient abuse. Using routine activities theory as a guide, the current study examines who is involved in patient abuse cases, the kinds of activities they commit, how vulnerability influences the existence of abuse as well as the ability of the system to serve as a guardian, and whether certain policies offer capable guardianship to residents. The following five research questions are addressed: (1) What are the characteristics of motivated offenders in patient abuse cases? (2) How can the actions of the motivated offenders be characterized? (3) How does vulnerability relate to victimization? (4) How does the criminal justice system handle the motivated offenders? and (5) How effective are the "capable" guardians?

**Method**

To address these questions, patient abuse cases described in the *Medicaid Fraud Report* (n = 801) between January 1997 and May 2002 were content analyzed. Medicaid Fraud Control Units, which provide data for the report, are the primary agencies involved in responding to patient abuse allegations. The fraud report describes the activities of Medicaid Fraud Control Units who share information about active investigations and prosecutions across the United States. Thus, data about offenses occurring in nursing homes in the United States are available from the reports.

Some of the descriptions described cases in which a

conviction was obtained, usually providing the sentence given to the offender, while some descriptions are of cases that are in preliminary stages of the justice process. Case descriptions from the fraud report are somewhat brief, usually including the name of the offender, his or her offense, the status of the case, and the nature of the offense. Sometimes the descriptions include information about the victim (e.g., age, gender, and whether they suffer from a cognitive impairment). Thus, the data were not collected as rigorously as social scientists might like. However, the data do provide a window to view this emerging issue in criminology and criminal justice.

**Analysis**

Manifest and latent content analyses were conducted on the patient abuse reports. Manifest content analysis was conducted by counting specific terms and phrases, such as the characteristics of the victims and the offenders. Latent content analysis involved considering the underlying themes that surfaced in the case descriptions. The variables analyzed in the current study included offender gender, victim gender, occupation, abuse type, abuser type, state and region, sentence, and presence of victim impairment.

Comments from the case reports are integrated in the findings section with statistical analyses to demonstrate patterns uncovered in the data. Univariate, bivariate, and multivariate analyses were conducted to address the questions set forth in this study. Univariate statistics are reported to describe the motivated offenders, their characteristics, and their actions. Bivariate and multivariate statistics are used to examine relationships between the variables and more thoroughly evaluate routine activities theory as platform for understanding nursing home abuse and criminal justice response.

**Findings**

*Motivated Offenders in Patient Abuse Cases*

Table 1 describes the characteristics of the patient abuse offenders. As shown in the table, nearly two-thirds of the offenders were female, and about three-fourths were aides or assistants. About ten percent were nurses and a handful of the offenders were doctors. In case descriptions where the underlying motivation for the misconduct was implied, offenders were characterized as serial abusers, pathological tormentors, or stressed-out abusers.

The empirical literature tends to describe the patient abusers as a stressed-out worker. Fifty-nine (24.6%) of the case descriptions supported this assumption about the situational dynamics surrounding patient abuse. Consider the following four cases:

**Table 1. The Motivated Offender: Offender Characteristics**

| | N | % |
|---|---|---|
| **Gender** | | |
| Female | 504 | 62.9 % |
| Male | 283 | 35.3 |
| Organization | 10 | 1.2 |
| Missing | 4 | 0.5 |
| **Total** | **801** | |
| **Occupation** | | |
| Aide | 468 | 73.0 % |
| Nurse | 79 | 12.3 |
| Doctor | 8 | 1.2 |
| Supervisor | 3 | 0.5 |
| Other | 83 | 12.9 |
| **Total** | **641** | |
| **Abuser type** | | |
| Serial | 115 | 47.9 % |
| Pathological/tormentor | 66 | 27.5 |
| Stressed-out | 59 | 24.6 |
| **Total** | **240** | |

*Note:* Percentages may not total 100 due to rounding.

- [The aide] was preparing to give a 92-year-old disoriented resident a shower when he struck [the aide] on the face…When [the resident] felt the water on his body, he hit [the aide]. Without hesitation, [the aide] slapped the resident with an open hand (MFR, October 1997:20).
- When a resident refused to take her medication because the dosage was incorrect, [the registered nurse] grabbed her hand and twisted it. At the same time, [the nurse] spilled a cup of water. She then slapped the resident in the face causing her to scream (MFR, May 2002:10).
- [The employee] became angry with a resident when she tried to leave the facility without permission. He yelled at the resident while hitting her with his hand on the resident' right buttock (MFR, May 2002:11).
- A caregiver kicked and choked a client because the client would not sit still to eat his food (MFR, March 2002:10).

The stress explanation usually conveys situations in which a seemingly stressed staff abuser immediately reacts negatively or even violently in retaliation to some relatively innocuous or common behavior of the resident.

Stressed abusers, however, do not always appear to act out immediately, nor can their actions be seen simply as retaliatory measures because they often go far beyond the initial action by the resident. The following two cases demonstrate how stress, while initiating the anger, appears to go beyond the typical picture of a reactive abuser:

- Apparently frustrated that the patient did not or could not relieve herself, [the caregiver] continued her verbal assault and pushed the patient back into her wheelchair. [The caregiver] then slapped the patient on the hand when she would not stop crying. The patient asked [the caregiver] not to hit her again. Shortly thereafter, two witnesses saw [the caregiver] slap the patient in the face so hard that it left a handprint on the patient's face (MFR, December 2001:10).
- [The resident] got into a confrontation…with [the employee] after he was denied a cigarette. After the confrontation, [the employee] approached [the resident] in the corner of his room and punched him with his fists approximately three to four times in the face (MFR, July 2000:5).

While clinical psychological diagnoses were unavailable, other offenders were characterized as pathological tormentors because of the severity of the acts and the lack of apparent provocation (at least as depicted in the fraud report). Sixty-six (28%) of the cases reviewed described offenders who could be characterized as pathological tormentors and whose actions can be characterized as callous and cruel. Consider a case in which "[an aide] taped a resident's buttocks together with masking tape" (MFR, March 1996:10). In another case "[The aide] was watching television in the resident's room when the resident coughed to clear her throat. Not wanting to be interrupted, [the aide] allegedly struck the patient on the shoulder, knocking her into the bed, and told her to 'shut up'" (MFR, November 1998:11). A third case description provides even more detail about the pain and anguish pathological tormentors cause:

> A certified nursing assistant found the…resident with a washcloth stuffed inside her tracheotomy mask, which effectively cut off her oxygen supply…Interviews with employees placed defendant in the residents' room approximately ten minutes prior to the discovery of the washcloth. [The aide] was not assigned to this resident and was under orders she was not to care for the resident because of past incidents…Interviews with facility employees stated the parents of the victim would leave a note on a chalk board in the victim's room saying, "Terri, we love you." When the family would leave, [the aide] would go into the victim's room and erase the message. Employees have seen her turn the television set away from the resident so she could not see the screen and turn family photographs face-down so the resident could not see the photographs (MFR, September 1998:13).

While many of the actions of pathological tormentors can be seen as emotional abuse, they are often extremely physically harmful to residents. The following case descriptions illustrate the physical harm perpetrated by pathological tormentors:

- [The aide] yanked the 80-year-old resident out of his wheelchair and slammed him into a metal armoire, then a bedrail at the head of the bed, then flung the victim down onto the bed, twirled him around and pulled his feet up to his head (MFR, May 2002:9).
- The patient's head was grabbed and pounded on the floor several times after he was struck with a knee to the midsection. Witnesses also claim they saw the suspect kick and 'stomp' the resident who offered no resistance (MFR, March 2002:9).
- According to a sworn affidavit by an eyewitness, [the defendants] waited for an 89-year-old patient of the facility to enter her room, wrapped a towel around her head and began hitting her in the face and arms (MFR, October 1999:10).
- The 77-year-old resident was smoking in a designated outside smoking area during unauthorized hours when [a security guard] allegedly told him to put out his cigarette. When the resident attempted to put the cigarette to his lips, [the security guard] grabbed the burning cigarette from his hands, threw it to the ground and crushed it with her foot. When the resident became agitated at the guard's actions, [the guard] grabbed his wrists, swung at him, and subsequently forcefully pushed him to the ground (MFR, March 1999:9).

While stress may be one source of the victimizations, it is more than plausible that the acts were committed for reasons other than stress.

In all, 115 of the cases (25%) included details suggesting that the offender had committed other offenses in the past. While these cases may involve pathological offenders, we label serial offenders as such because of their abusive history. Here are a few examples of serial abusers from the fraud report:

- The former mobile x-ray technician pleaded guilty on April 6, 2000, to charges of Lewd and Lascivious Conduct based on his visit to a nursing home when he inserted his tongue in the elderly person's mouth and touched her breast during an e-ray for a broken hip. On August 9, 1999, [the former technician] also pleaded guilty to three counts of simple assault for a similar incident at a nursing home in New Hampshire just ten days after the molestation (MFR, August 2000:7).
- In conducting a criminal background check on [the aide]…it was discovered that he previously had been court-martialed from the U.S. Army for lewd and lascivious contact with a minor and sentenced to federal prison. In his nursing home employment application, [the aide failed to note any prior criminal convictions. [The aide] while employed at the facility, forcibly raped a 92-year-old patient on five separate occasions between September and October 1997 (MFR, July 2000:17).
- [The investigator] interviewed six staff members who witnessed [the aide] physically abuse patients by striking them with a closed fist or open hand. They also witnessed [the aide], while assisting patients with showers, spray them in the face to quiet them and control them and witnessed several instances of verbal abuse (MFR, July 1998:10).
- The complaint alleged that [the employee] abused eight patients. The abuse ranged from harassing patients by flicking water in their faces, to striking one extremely vulnerable resident in the head. The complaint alleged that [the employee] threw a resident with acute osteoporosis several feet across a room (MFR, April 1996:13).

Serial abusers appear more similar to pathological tormentors than stressed abusers. Their actions generally appear to be particularly sadistic with little or no precipitating actions by victims. For example, one offender was accused of taking a wooden clothespin from the patient's closet and clipping it to his scrotum, and on another occasion, taking the top sheet on the patient's bed, wrapping it around his ankles, and pulling his legs up over his head (MFR, January/February 2000:25). An offender was seen on several occasions bracing himself "against a wall to gain leverage and push on a resident's bladder with his fist" (MFR, May/June 1999:15).

Like pathological tormentors, serial abusers also tended to commit physically harmful acts. A few case descriptions from the fraud report illustrate this pattern:

- He transported residents to the dining room but would not seat them at the table and would not assist residents when they asked for help in transporting and toileting. He told another certified nurses aid to shave a resident's legs using a pig knife (the type of knife used to slaughter pigs in Mexico). He scolded elders for needing PERI care, threw a soiled diaper at one resident and on more than ten occasions "pushed and slammed" another in her bed while assisting her. (MFR, September/October, 2000:23).
- The defendants repeatedly and intentionally harmed a 60-year-old dementia resident by physically and verbally abusing him. The assaults occurred on two separate occasions. Details of the assaults included hitting, kicking, and kneeing the resident, dragging him up a flight of stairs and down a hall by his feet, hitting him with a toilet plunger and throwing him into a tub and spraying him with cold water (MFR, September 1999:9).
- [The aide] was witnessed assaulting five elderly residents, all of whom are over 80 years of age, on seven different occasions. The most disturbing of the allegations…involves an incident in which another employee witnessed [the aide] forcing an 83-year-old female patient to eat her own feces. [The aide] allegedly took a handful of the patient's feces and shoved it into her mouth, making her chew and swallow it. [The aide] then allegedly used a towel to wipe the corners of her mouth. When the coworker questioned [the aide] on how she could do such a thing, she allegedly laughed (MFR, June 1998:9).
- [The aide] was accused of four separate attacks including one in which he groped the breast of an 84-year-old woman, and the repeated attack on a screaming 93-year-old female patient by inserting his fingers in her rectum. [The aide] is also charged with shoving a 100-year-old woman into a chair…and hitting an 83-year-old male patient repeatedly on the head, legs, and arms (MFR, April 1998:7).

*Characterizing the Actions of the Motivated Offenders*

Table 2 shows the primary types of offenses committed by the patient abusers. Over two-thirds of the cases involved physical abuse cases, with about half being instances where abusers were accused of hitting residents. A handful of physical abuse cases involved offenders pushing (n = 25) or kicking (n = 20) residents, while six involved situations in which aggressors forcefully rubbed the residents' feces on the resident.

Nearly ten percent of the cases were sexual abuse cases. Using a classification scheme describing elder sexual abuse set forth by Ramsey-Klawsnick, sexual

abuse cases were classified as hands-on (n = 42), harmful genital contact (n = 18), and hands-off (n = 2). Hands-on sexual abuse cases involve situations in which the offender touches the victim sexually, but sexual intercourse does not occur. The following three cases illustrate the kinds of behaviors characterized as hands-on sexual abuse cases:

- A certified nurse's aide for sexually fondling an elderly mentally retarded patient at a nursing home (MFR, September/October 2000:12).
- According to the Department of Justice's criminal complaint, in August 2000, [the offender], while employed as a certified nursing assistant at Meadow Park Health Care Center, masturbated a developmentally disabled patient who was in his care and allowed the patient to masturbate him (MFR, January 2002:11).
- A nursing assistant at a health care and rehabilitation facility. After [the aide] bathed a vulnerable adult (VA), the VA asked him to shave her legs. Sawyer refused, but stated that he needed to shave her "uterus area." The VA had pointed to her pubic region and said that [the aide] shaved her there and then began rubbing the opening of her vagina, claiming he needed to get a "specimen," and digitally penetrated the VA. [The aide] also rubbed the VA's breasts, telling her not to tell anyone. The VA told [the aide] not to rub her clitoris and [the aide] told her to be quiet. (MFR, March April 2001:13).

Harmful genital contact cases involve sex abuse cases in which intercourse (including oral, vaginal, and anal sex) occurs. About one in fifty of the patient abuse cases involved some form of harmful genital contact. Hands-off sexual abuse occurs when offenders commit some sexually abusive act without touching the patient. This study revealed two hands-off sexual abuse cases, both involving instances where an aide exposed himself, and were handled by the fraud control units.

Nearly ten percent of the offenders were involved in cases characterized as duty-related abuse. Duty-related abuse cases are those in which offenders failed to perform some specific function of their jobs. Failure to report abuse was the most common duty-related offense (approximately 25%). Duty-related abuses were also characterized as accidental and intentional abuses. Accidental duty-related abuse occurred when patients failed to do their job in unintentional ways. For example, one patient did not know that a valve on the hot tub was broken and subsequently placed an elderly resident in the tub without verifying that the equipment was functioning correctly.

**Table 2. Offense Types**

| Offense type | N | % |
|---|---|---|
| Physical | 542 | 67.7 % |
| Sexual | 78 | 9.7 |
| Duty-related | 78 | 9.7 |
| Neglect | 54 | 6.7 |
| Drug Theft | 15 | 1.9 |
| Emotional abuse | 13 | 1.6 |
| Financial abuse | 10 | 1.2 |
| Unclear | 11 | 1.4 |
| **Total** | **801** | |

*Note:* Percentages may not total 100 due to rounding.

The resident suffered severe burns. In intentional duty-related abuse cases, the intent is clearly established. In a handful of cases, for example, aides tried lifting patients on their own without the assistance (which is required by law for certain patients) of others. These sorts of cases generally only come to the attention of the authorities when the victim experiences some form of harm from the duty-related abuse. They are intentional in the sense that they intentionally violate some rule, not that they necessarily intend to harm.

Neglect was reported in about seven percent of the cases. Neglect occurs when caregivers fail to provide proper care to residents. “Good employee” neglect involved instances when offenders were failing to provide care because they were busy to meet other demands of the workplace. This generally entailed situations in which workers were cleaning a resident’s room or feeding one patient when they were supposed to be providing some form of care to another patient. Of greater concern were cases of neglect where workers were failing to provide care in a way that ran completely counter to the goals of the administrators. Neglect cases of this sort included cases where the worker simply fell asleep on the job or left work hours before their shift was over.

Nursing home staff personnel were also responsible for a handful of drug theft (n = 15), emotional abuse (n = 13), and financial abuse (n = 10) cases. Such offenses are likely far more common than these figures indicate because, if reported at all, many of these offenses would be handled by local authorities, not the fraud control units.

*Vulnerability and Victimization*

Table 3 shows the characteristics of the victims for those cases in which this information was available. As shown in the table, victims were almost evenly split in terms of gender. Most of the victims were 70 years of age

or older, though a sizeable proportion of them were below the age of 50 (n = 58).

The fraud report described 196 cases with patients suffering from some form of cognitive impairments. Impairments were evenly split between Alzheimer's, dementia, mental retardation, and other cognitive impairments. While abuse type did not vary by impairment type, the mere presence of impairment was found to be related to the type of abuse. Approximately 36% of sexual abuse victims had some form of a cognitive impairment compared to about 23% nonsexual abuse victims (Chi-square = 6.27, $p < .01$, phi = .09).

*The Criminal Justice System Response to Motivated Offenders*

We selected out cases where the sanction(s) the offender received was provided (n = 467). As is standard in the literature, we focused on two types of sanctions—one qualitative and one quantitative. The qualitative measure differs from most studies by moving beyond a simple dichotomy (the in/out incarceration decision) to an ordinal trichotomy (probation, community service or fine, or a period of incarceration). Like other studies of sentencing, the quantitative variable is length of incarceration and only includes those sentenced to a period of incarceration. As is common in this type of study, we included a hazard rate variable to at least partially control for sample selection biases (see Berk, 1983).

Independent variables were limited because there were considerable missing data on cases in which sentencing data were available. Importantly, missing data on the severity of the offense and type of offender and criminal histories precluded the use of these variables. We were, however, able to include sex of the offender, whether the offense was a sex offense or nonsex/nonphysical offense (physical offense was the reference category), whether the victim was cognitively impaired, whether the offense was negotiated through a plea agreement, and whether the case took place in a state with mandatory reporting laws or penalty enhancement statutes. With listwise deletion, we were able to maintain 413 cases (88%) of the cases where sentencing data were available. Descriptive data are presented in Table 4.

Given the nature of the dependent variables (no sanction, fine or community service, or incarceration) we first used ordinal logistic regression to assess the independent effects of case characteristics on sanction severity. A test of the proportional odds assumption of the model suggests that the assumption may not be reasonable (Chi-square = 44.99, df = 7, $p < .01$). Because this test is somewhat conservative in that it is perhaps to easy to reject the null hypothesis with consequences of little import (Peterson and Harrel, 1990), we also ran a standard logistic regression model that predicted incarceration against the other more lenient sentences, as is common in the literature (e.g., Engen and Gainey, 2000). The data are presented in the first column of Table 5.

In contrast to much of the general research on sentencing (see Daly and Tonry, 1997 for a recent review), both models suggest that females are not sentenced on average any less severely than males in cases of nursing home abuse. The model shows some evidence that the type of offense was related to sentence severity in that sex offenses were sentenced somewhat more severely than physical abuse cases (both models). The "other" category

**Table 3. Suitable Targets: Victim Characteristics**

| Characteristic | N | % |
|---|---|---|
| **Gender** | | |
| Female | 218 | 52.7 % |
| Male | 196 | 47.3 |
| **Total** | **414** | |
| **Age** | | |
| Below 60 years | 71 | 20.6 % |
| 61-70 years | 24 | 7.0 |
| 71-80 years | 69 | 20.1 |
| 81-90 years | 112 | 32.6 |
| 91-99 years | 64 | 18.6 |
| 100+ years | 4 | 1.2 |
| **Total** | **344** | |
| **Impairment** | | |
| Mental illness | 57 | 29.1 % |
| Alzheimer's | 47 | 24.0 |
| Dementia | 47 | 24.0 |
| Other | 45 | 23.0 |
| **Total** | **196** | |

Note: Percentages may not total 100 due to rounding.

**Table 4. Descriptive Statistics on Sentencing and Factors Related to Sentencing**

| | Proportion | (SD) |
|---|---|---|
| **Female offender** | .64 | (.48) |
| **Offense type** | | |
| Sex offense | .10 | (.29) |
| Other offense | .17 | (.38) |
| **Cognitive impairment** | .25 | (.43) |
| **Plea agreement** | .70 | (.46) |
| **Mandatory reporting** | .70 | (.46) |
| **Penalty enhancement** | .43 | (.50) |

of offenses (generally seen as less severe) was sentenced similarly to cases of physical abuse in the first model, but the second model showed that these cases were less likely to result in incarceration than physical abuse cases. In both models there was some evidence that abusers of the cognitively impaired received more lenient sanctions than those who abused those with normal mental functioning. As previous research shows (e.g., Albonetti, 1997), cases that are resolved through plea agreements tend to result in less severe sanctions than those that go to trial. Finally, we find little effect of legal guardians of the elderly. Both models show similar sentencing practices in states with mandatory reporting statutes as in those without them. The influence of penalty enhancements is even more disturbing, as states with penalty enhancements actually have mete out lower sentences than states without these enhancements. There is some evidence that the sanctions carried out in states with penalty enhancement are lower than in states without them.

**Discussion**

The results of this study call into question current understanding of patient abuse, as well as the usefulness of laws designed to protect the elderly. While some of the motivated offenders can be characterized as stressed abusers, more of them can be seen as either pathological tormentors or serial abusers. It is important to point out that the distinction drawn between pathological tormentors and serial abusers may be an artifact of coding as the availability of information was limited. Serial abusers are those who got caught more than once committing harmful acts. Pathological tormentors simply were caught once and it is entirely likely that many of the pathological tormentors are actually serial abusers who have, to date, gotten away with their misconduct. This does not appear to be a major flaw of the data, and the fact remains that a majority of motivated offenders in patient abuse cases do not appear to be stressed abusers as is often portrayed in the literature. Rather, they appear to be motivated by power and control desires.

**Table 5. Ordinal Logistic Regression of Sentence Type and Logistic Regression of the Incarceration Decision**

| | Ordinal logistic estimates (SE) | | | Logistic incarceration estimates (SE) | | |
|---|---|---|---|---|---|---|
| Female | -.27 | (.22) | | -.27 | (.26) | |
| Sex offense | .77 | (.38) | * | 1.19 | (.41) | * |
| Other offense | -.26 | (.25) | | -.83 | (.37) | * |
| Cognitive impairment | -.74 | (.23) | * | -.52 | (.29) | * |
| Plea agreement | -.51 | (.22) | * | -.49 | (.25) | * |
| Mandatory reporting | .17 | (.23) | | -.18 | (.28) | |
| Penalty enhancement | -.41 | (.22) | * | .02 | (.26) | |
| Nagelkerke r-square | .08 | | | .11 | | |

* one-tailed test, significant at $p < .05$

The three types of offenders discovered in the data also provide theoretical fodder for the routine activities approach. Specifically, the first two types of offenders, stressed-out abusers and pathological tormentors, provide insights into the structural and psychological factors that may encourage or motivate potential offenders. The fact that the empirical evidence documents the existence of serial abusers suggests that while most anyone can commit crimes (Felson, 1998), there is clear variation across individuals in their propensity to commit crimes against the elderly, and that research on motivated offenders should move beyond either a description of the motivated offender as a constant or as simply a dichotomous vision of motivated offenders and others.

As far as vulnerability is concerned, the results uncovered in this study, like previous research (see Petersilia, 2001), suggest that those with certain impairments are more prone to sexual abuse than others. From a routine activities perspective, it is important to note that this vulnerability works in conjunction with other elements to increase victims' risks. Some potential victims may take preventive measures to reduce risk (Cohen and Felson, 1979; Mesch, 2000; Rountree, Wilcox, and Land, 1996). Those with certain disabilities may be unable to take measures that would provide them with capable guardians. Residents of long-term care settings are forced to rely on formal measures to prevent victimization.

As shown in this study, formal remedies such as penalty enhancement statutes and mandatory reporting laws do not appear to effectively serve as capable guardians. This is not entirely unexpected. Felson (1998) argues quite persuasively that the criminal justice system is unlikely to be a very capable guardian, since so much crime is undetected and unreported, and even if someone is apprehended and punished, the punishment is unlikely to be swift. Furthermore, our measures of the presence of mandatory reporting and penalty enhancements are clearly not very direct measures of capable guardianship. Examples of more direct measures are the staff-to-patient ratio or the number of place managers who can monitor the activities of other workers who may be potential offenders. On a more positive note, while these legal sanctions are certainly not adequate capable guardians, they may lay a foundation that helps potential guardians.

Based on these findings, a number of implications for theory, policy, and research arise. There are at least two implications for policy, each of them dealing with specific elements of routine activities theory. First, traditionally patient abuse has been explained by stress explanations, and prevention strategies recommended in the literature have suggested practices in line with these explanations, such as better training and increased pay. In terms of policy, we would not suggest that such practices be hindered. Rather, we suggest that other avenues should be explored as well, such as informing administrators of the importance of place managers in controlling the environment and monitoring potentially stressed-out workers. Empowering place managers so they know that reporting problems is a good thing and that their reports will be taken seriously, as opposed to something that will come back to haunt them, can also be important.

Second, if training, better pay, mandatory reporting laws, and penalty enhancement statutes do not act as effective guardians, one must look to other strategies for effective guardianship. Vulnerability is not a random situation, but is created by practices and strategies that have been implemented. What practices and strategies could control patient abuse? One possibility is to increase the presence of the criminal justice system in institutional settings. More realistically, more hiring and better training of place managers may play a more direct role in monitoring potential offenders and victims. Better screening of applicants, including criminal background checks and psychological evaluations may help. As Arnovitz (2002:4) points out, "federal law requires states to maintain a registry of nurse aides—specifically, all individuals who have completed an approved nurse aide training and competency program." Very few states, however, require criminal background checks. Thought should be given to increasing the use of criminal background checks. Training programs or nursing homes could be given the task of doing the checks. Given that our research shows that many of the offenders committed their offenses after completing the training programs, assigning this task to nursing homes seems to be a better strategy.

Others have suggested that nursing aides work in teams to ensure the presence of witnesses (i.e., guardians) should conflict occur (Payne and Cikovic, 1995). Teams assigned by management should help to address the influence that staff characteristics might have in contributing to abuse. Whatever the strategy, it seems prudent that long-term care settings take actions to keep motivated offenders away from residents.

Two related theoretical implications arise. First, Kennedy and Baron (1993) have recommended adding a choice element and a subcultural theme to routine activities theory to broaden its explanatory power. We join them in calling for an integration of these approaches with routine activities theory. The notion of choice is particularly important. According to Felson (1986:119), "People make choices, but they cannot choose the choices available to them." This assumes that there are no ways to affect individuals' choices beyond strategies that alter available choices. We believe that offenders often choose to abuse patients, and measures can be taken to make them choose other employment or to restrain their motivations.

On a related point, routine activities theory is more concerned with the situational aspects of the crime rather than the intent of the offender (Felson and Cohen, 1980). We believe this is a limitation of standard uses of routine activities theory. Both formal and informal crime prevention strategies are based, in part, on the intent of the offender (e.g., because it was believed that stress caused patient abuse in the past, recommendations to reduce it included better training, support, and increased pay). Ignoring the role of intent possibly overlooks the most dangerous motivated offenders and does not necessarily point us to the most appropriate or effective guardians.

A number of questions remain for future research. Penalty enhancement and mandatory reporting laws are designed to prevent cases of elder abuse in the community as well as those occurring in long-term care settings. Although our results do not suggest strong effects, it may be that such legislation is important but the laws are not causally proximate factors affecting victimization. More research should examine both mediating and moderating effects of these types of laws. For example, on the grounds that capable guardianship varies from community to community (Miethe and McDowall, 1993), research should address whether guardianship effectiveness varies across communities. For example, how does routine activities theory fare in explaining patient abuse in socially-disorganized communities? These and other questions remain for future researchers to address.

This study is not without limitations. First, the data are derived from Medicaid Fraud Reports, which do not necessarily reflect a representative sample of cases. Indeed, they exclude cases that are reported directly to the local police, unless the police notify or consult with Medicaid Fraud Units. Furthermore, the data were not collected by and for social science or criminal justice research purposes and the quality of data may be limited. Yet we argue the reports offer rich qualitative data, through which quantitative data can be produced through content analyses. These data can be used to provide an

important and timely look at a neglected area of criminal abuse.

In closing, Felson (1986:21) points out that "changes in the daily life of the community alter the amount of criminal opportunity in a society, hence altering crime rates." The graying of America has led to "changes in the daily life" for members of society. With even more elderly persons in the future, more changes are sure to come. In particular, more elderly persons mean more elderly victims. It is imperative that criminologists and criminal justice practitioners better understand the victimization experiences of elderly persons, as their routine activities are not the same as those of the younger population.

**References**


Administration on Aging. 1998. *The National Elder Abuse Incidence Study, Final Report*. Washington, D.C.: Administration on Aging. <http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/AbuseReport_Full.pdf>.

Albonetti, Celesta A. 1997. "Sentencing Under the Federal Sentencing guidelines: Effects of Defendant Characteristics, Guilty Pleas, and Departures on Sentencing Outcomes for Drug Offenders." *Law and Society Review* 31:789-822.

Allen, Priscilla D., Kathy Kellett, and Cynthia Gruman. 2003. "Elder Abuse in Connecticut's Nursing Homes." *Journal of Elder Abuse & Neglect* 15:19-43.

Arnovitz, Leslie G. 2002. *Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse.* Washington D.C.: United States General Accounting Office.

Berk, Richard A. 1983. "An Introduction to Sample Selection Bias in Sociological Data." *American Sociological Review* 48:386-398.

Castledine, George. 2005. "Professional Misconduct: Nurse who Physically Abused Her Patients." *British Journal of Nursing* 14:633-644.

Cohen, Lawrence and Marcus Felson. 1979. "Social Change and Crime Rate Trends." *American Sociological Review* 44:588-608.

Crumb, Deborah J. and Kenneth Jennings. 1998. "Incidents of Patient Abuse in Health Care Facilities are Becoming More and More Commonplace." *Dispute Resolution Journal* 1998:37-43.

Daly, Kathleen and Michael Tonry. 1997. "Gender, Race, and Sentencing." *Crime and Justice: A Review of Research* 22:201-252.

Eck, John. 1998. "Improving the Management of Rental Properties with Drug Problems: A Randomized Approach." Pp. 161-186 in *Civil Remedies and Crime Prevention*, edited by L. Mazerolle and J. Roehl. Crime Prevention Studies, Vol. 9. Monsey, NY: Criminal Justice Press.

Engen, Rodney, L. and Randy R. Gainey. 2000. "Modeling the Effects of Legally Relevant and Extralegal Variables Under Sentencing Guidelines." *Criminology* 38:1207-1230.

Faggiani, Donald and Myra G. Owens. 1999. "Robbery of Older Adults." *Justice Research and Policy* 1:97-117.

Felson, Marcus. 1986. "Linking Criminal Choices, Routine Activities, Informal Control, and Criminal Outcomes." Pp. 119-128 in *The Reasoning Criminal*, edited by D. Cornish and R.V. Clarke. New York, NY: Springer.

Felson, Marcus. 1992. "Routine Activities and Crime Prevention." *Studies on Crime and Crime Prevention* 1:30-34.

Felson, Marcus. 1996. "A 'Routine Activity' Analysis of Recent Crime Reductions." *Criminologist* 22:1.

Felson, Marcus. 1998. *Crime and Everyday Life* (2nd ed.). Thousand Oaks, CA: Sage.

Felson, Marcus and Lawrence Cohen. 1980. "Human Ecology and Crime: A Routine Activity Approach." *Human Ecology* 8:389-406.

Friedrichs, David. 1996. *Trusted Criminals*. Belmont, CA: Wadsworth.

Harris, Diane K. and Michael L. Benson. 1996. "Theft in Nursing homes: An Overlooked form of Elder Abuse." Pp. 171-178 in *Advances in Bioethics*, edited by L.B. Cebik, G.C. Graber, and F.H. Marsh. Greenwich, CT: JAI Press.

Harris, Diane K. and Michael L. Benson. 1998. "Nursing Home Theft: The Hidden Problem." *Journal of Aging Studies* 12:57-67.

Harris, Diane K. and Michael L. Benson. 1999. "Elder Abuse in Nursing Homes." *Journal of Elder Abuse and Neglect* 10:141-151.

Hodge, Paul D. 1998. "National Law Enforcement Programs to Prevent, Detect, Investigate, and Prosecute Elder Abuse and Neglect in Health Care Facilities." *Journal of Elder Abuse & Neglect* 9:23-41.

Jenkins, Anne and John Braithwaite. 1993. "Profits, Pressures, and Corporate Lawbreaking." *Crime, Law, and Social Change* 20:221-232.

Kennedy, Leslie W. and Stephen W. Baron. 1993. "Routine Activities and a Subculture of Violence." *Journal of Research in Crime and Delinquency* 30:88-112.

Kennedy, Leslie W. and Robert A. Silverman. 1990. "The Elderly Victim of Homicide." *Sociological Quarterly* 31:307-319.

Lachs, Mark and Karl Pillemer. 1995. "Abuse and Neglect of Elderly Persons." *New England Journal of Medicine* 332:437-443.

Lasley, James R. 1989. "Routine/lifestyles and Predatory Victimization." *Justice Quarterly* 6:529-542.

McCarthy, Michael. 2002. "Report Finds Abuse in United States Nursing Homes Goes Unreported and Unpunished." *Lancet* 359:860.

*Medicaid Fraud Report*. 1997-2002. National Association of Attorneys General. Washington D.C.: U.S. Government Printing Office.

Mercer, Susan, Patricia Heacock, and Cornelia Beck. 1996. "Nurse's Aides in Nursing Homes." *Journal of Gerontological Social Work* 21:95-113.

Mesch, Gustavo. 2000. "Perceptions of Risk, Lifestyle Activities, and Fear of Crime." *Deviant Behavior* 21:47-62.

Miethe, Terance D., Mark C. Stafford, and Douglas Sloane. 1990. "Lifestyle Changes and Risks of Criminal Victimization." *Journal of Quantitative Criminology* 6:357-376.

Miethe, Terance D. and David McDowall. 1993. "Contextual Effects in Models of Criminal Victimization." *Social Forces* 71:741-760.

Moskowitz, Seymour. 1998. "Private Enforcement of Criminal Mandatory Reporting Laws." *Journal of Elder Abuse and Neglect* 9:1-22.

Nelsen, Candice and Lin Huff-Corzine. 1998. "Strangers in the Night: An Application of the Lifestyle-Routine Activities Approach to Elderly Homicide Victimization." *Homicide Studies* 2:130-159.

Nelson, H. Wayne, Ruth Huber, and Kathy L. Walter. 1995. "The Relationship Between Volunteer Long-Term Care Ombudsmen and Regulatory Nursing Home Actions." *Gerontologist* 35:509-515

Netting, F. Ellen, Ruth N. Paton, and Ruth Huber. 1992. "The Long-Term Care Ombudsman Program: What the Complaint Reporting System Can Tell Us." *Gerontologist* 32:843-849.

Northway, Ruth, Rachel Davies, Robert Jenkins, and Ian Mansell. 2005. "Evidencing Good Practice in Adult Protection." *Journal of Adult Protection* 7:28-36.

Paton, Ruth N., Ruth Huber, and F. Ellen Netting. 1994. "The Long-Term Care Ombudsman Program and Complaints of Abuse and Neglect: What Have We Learned?" *Journal of Elder Abuse and Neglect* 6:97-115.

Payne, Brian K. 2000. *Crime and Elder Abuse: An Integrated Perspective*. Springfield, IL: Charles C. Thomas.

Payne, Brian K., Bruce L. Berg, and Kristin Byars. 1998. "A Qualitative Examination of the Similarities and Differences of Elder Abuse Definitions among Four Groups." *Journal of Elder Abuse and Neglect* 10:63-86.

Payne, Brian K., Bruce L. Berg, and LaDonna James. 2001. "Attitudes about Sanctioning Elder Abuse Offenders among Police Chiefs, Nursing Home Professionals, and Students." *International Journal of Offender Therapy and Comparative Criminology* 43:363-382.

Payne, Brian K., Bruce L. Berg, and Jeffrey Toussaint. 2001. "The Police Response to Elder Abuse." *Policing: An International Journal of Police Strategies and Management* 23:581-601.

Payne, Brian K. and Bruce L. Berg. 2003. "Perceptions about the Criminalization of Elder Abuse among Police Chiefs and Ombudsmen." *Crime and Delinquency* 49:439-460.

Payne, Brian K. and Richard Cikovic. 1995. "An empirical examination of the characteristics, causes, and consequences of elder abuse in nursing homes." *Journal of Elder Abuse and Neglect* 7:61-74.

Payne, Brian K. and Randy R. Gainey. 2005. *Family Violence and Criminal Justice*. (2nd ed.) Cincinnati, OH: Anderson.

Payne, Malcolm. 2005. "Adult Protection Cases in a Hospice." *Journal of Adult Protection* 7(2), 4-12.

Petersilia, Joan. 2001. "Crime Victims with Developmental Disabilities." *Criminal Justice and Behavior* 28: 655-694.

Peterson, Bercedis and Frank E. Harrel. 1990. "Partial Proportional Odds Model for Ordinal Response Variables." *Applied Statistics* 39:205-217.

Pillemer, Karl A. and Bachman, Ronet. 1991. "Abuse of Patients in Nursing Homes." *Gerontologist* 29:314-320.

Pillemer, Karl A. and David W. Moore. 1990. "Highlights from a Study of Abuse of Patients in Nursing Homes." *Journal of Elder Abuse and Neglect* 2:5-29.

Pillemer, Karl A. and David W. Moore. 1990. "Helping and Hurting: Predictors of Maltreatment of Patients in Nursing Homes." *Research on Aging* 13:74-95.

Rountree, Pamela Wilcox and Kenneth C. Land. 1996. "Burglary Victimization, Perceptions of Crime Risk, and Routine Activities." *Journal of Research in Crime and Delinquency* 33:147-180.

Shaw, Mary. 1998. "Nursing Home Resident Abuse by Staff." *Journal of Elder Abuse and Neglect* 9:1-6.

Stafford, Mark and Mark Warr. 1993. "A Reconceptualization of General and Specific Deterrence." *Journal of Research in Crime and Delinquency* 30:123-135.

Stannard, Charles. 1973. "Old Folks and Dirty Work: The Social Conditions for Patient Abuse in a Nursing Home." *Social Problems 20*:329-342.

United States General Accounting Office. 2002. *Nursing Homes: More Can be Done to Protect Residents from Abuse*. Washington, DC: GAO.

Vladeck, Bruce C. and Marvin Feuerberg. 1995. "Unloving Care Revisited." *Generations* 19: 9-13.

---

**About the authors:**

**Dr. Brian K. Payne** is professor and chair of the Sociology and Criminal Justice department at Old Dominion University. He received his PhD in 1993 in Criminology from Indiana University of Pennsylvania. He is the director the ODU Center for Family Violence Education and Research. He is the author of five books including *Crime and Elder Abuse: An Integrated Perspective, Crime in the Home Health Care Field*, and *Family Violence and Criminal Justice*. His research focuses on social control, family violence, and a criminological understanding of elder abuse.

**Randy R. Gainey** received his Ph.D. in Sociology from the University of Washington in 1995. He is currently an associate professor and graduate program director in the Department of Sociology and Criminal Justice at Old Dominion University. He has published widely in a number of areas including: racial disparities in sentencing, the use of alternative sanctions, the fear of crime, and substance use and abuse. He is a member Center for Family Violence Education and Research (CFAVER) and consults with Virginia Sexual and Domestic Violence Data Collection System (VAdata).

**Contact information:**

**Corresponding author:** Brian K. Payne, Department of Sociology and Criminal Justice, Old Dominion University, Norfolk, VA 23529. Phone: (757)683-3935. E-mail: bpayne@odu.edu.