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Elder Abuse Identification and Intervention: Final Report to Blue Cross-Blue Shield of Michigan Foundation

Mary C. Sengstock
Wayne State University, marycay910@wowway.com

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ELDER ABUSE IDENTIFICATION AND INTERVENTION

Final Report to Blue Cross Blue Shield of Michigan Foundation

Project 1015ii

by

Dr. Mary C. Sengstock, Ph. D., C.C.S., Principal Investigator

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Executive Summary:
"Elder Abuse Identification and Intervention"
Final Report to Blue Cross Blue Shield of Michigan Foundation
Project 1015ii
Dr. Mary C. Sengstock, Ph. D., C.C.S., Principal Investigator

- This project focused on abuse and neglect of the elderly, a major problem that affects older adults, and has serious consequences for their health and welfare.
- The ultimate goal of this project was to evaluate the effectiveness of approaches to identification and intervention with abused elders, to suggest any changes which might be advisable, and to develop and implement a new model or models.
- The objectives of the project were to: review the Mandatory Reporting Model for the and assistance to abused elders in Michigan; determine whether changes were necessary; develop a new model or models; and assess the feasibility of the new models with professional workers in private and public agencies in the state.
- Both quantitative and qualitative data were collected. The quantitative data included information on reported cases of abuse, neglect, and endangerment from Macomb, Oakland, and Wayne counties, collected by the Michigan Department of Human Services Adult Protective Services Department.
- Case data included information from the State on the types of abuse, neglect, endangerment frequently reported; types of professionals who report the abuse; and whether or not the cases were substantiated.
- Qualitative data were collected to determine the effectiveness of the current system of reporting and evaluating elder abuse cases.
- Two types of qualitative data were used. First, the *Michigan State Governor's Task Force on Elder Abuse Final Report* was used to provide a description of the goals and objectives of the State's elder abuse assistance program. Second, focus groups were conducted with agencies, both public and private, at the local level to determine the effectiveness of the State's system for assisting abused elders.
- Quantitative data on abuse cases in Michigan records were obtained during two points of time, Summer, 2006 and Winter, 2007. A total of 210 cases were included in the 3 counties studied. APS workers were able to substantiate 84.3% of the cases in the summer, and 75.9% in the winter.
- Regarding the type of workers reporting, 39.0% of the cases were reported by health care providers. Mental health and social services agencies each reported 23.8% of cases. Other government agencies reported 11.4% of cases. APS workers were able to substantiate 80% of the cases, with 20% not being substantiated.
- The *Governor's Task Force Report* was useful in indicating some concerns regarding the effectiveness of the State's approach to elder abuse. In particular, the report stated that more attention should be given to the most frequent types of abuse, financial abuse, neglect, and self-neglect. It also urged the greater involvement of agencies in banking, criminal justice, and the courts.
- Interviews with 14 focus groups were conducted to evaluate the effectiveness of the Michigan Adult Protective Services approach. Private agency focus groups were conducted with professionals working in agencies which are mandated reporters of

abuse. Public agency focus groups were held with personnel working in APS offices in the Detroit area and at the State level.

- Workers in the APS system were concerned that they often received insufficient information from reporting agencies to implement the State's program effectively. Often the reports lacked information sufficient even to conduct an effective investigation. They also reported a lack of resources available to do their jobs effectively, and felt that officials in other departments of State and local government, such as courts and police, were unresponsive to their concerns.
- Reporting agencies complained that they did not receive adequate information from APS about their reported cases. They were concerned about: the considerable amount of time required to collect the data the State required; confusion about which cases should be reported to which State agency; and uncertainty concerning the format the reports should take.
- Both public and private agencies believed that more communication and coordination was necessary among all agencies and the State, as well as greater training for workers at all levels. Concern about ineffective services to mentally incompetent adults was also expressed in both types of agencies.
- There was considerable agreement that a standardized form for reporting and a registry for abusers would be useful; workers had little hope this would occur.
- Concerns about violations of confidentiality of information were mentioned by all agencies. They also believed there was a need for greater emphasis on the more frequently observed types of abuse, namely, financial abuse, neglect, and self-neglect. This issue also appeared in the *Task Force Report*.
- To summarize, the project's major objectives were: to evaluate the current model for identifying and providing services to abused elders; to determine whether alterations in the model are necessary; and to recommend alternatives, if appropriate.
- Two levels of recommendations are submitted, one focusing on the current model, the other suggesting additional approaches.
- Recommendations on the Current Model: "Mandatory Reporting": The model is effective primarily with professionals in the medical and social work professions. However, the model should be improved by providing more training opportunities for mandatory reporters and APS workers; increasing the number of APS workers to ensure adequate investigations at the State level; development of mechanisms to improve communication between agency and State workers (a "Focal Point"); adding a standardized reporting form and a registry for abusers.
- Recommendations for New Model(s): The Mandatory Reporting Model does not appear to be effective with certain types of agencies, or with some types of abuse. In particular, the current model appears is less effective in identifying some of the most frequent types of abuse, financial abuse, neglect, and self-neglect. It also fails to gain support from agencies most familiar with these issues.
- Hence the second recommendation suggests the addition of other models, better adapted to working with legal and criminal justice agencies, banks and financial institutions. Legislative and executive branches should work together to develop and implement these new procedures, and ensure that adequate funding exists to implement efforts to identify and assist abused elders, and decrease the incidence of abuse.

"Elder Abuse Identification and Intervention"

Final Report to Blue Cross Blue Shield of Michigan Foundation[1]

Project 1015ii

Dr. Mary C. Sengstock, Ph. D., C.C.S., Principal Investigator

PROJECT GOALS AND OBJECTIVES:

Goal of Project: The goal of the project was to evaluate the model for the identification of elder abuse currently being used in the State of Michigan, to suggest any changes which might be advisable, and to develop a new model or models, if that should seem to be required for the safety and well being of older adults in Michigan.

Project Objectives: Specific objectives were fourfold. They included: to review of the current model for the identification and assistance to abused elders in the State of Michigan; to determine whether changes in this model were necessary; to develop a new model, or models, if that seemed appropriate; and to assess the feasibility of these models with professional workers in both private and public agencies in the state.

RATIONALE OF THE PROJECT:

Research consistently shows that abuse of the elderly is a problem which disproportionately affects the more deprived members of the elderly population, and has serious consequences for their health and welfare. Not only are these elders affected by the abuse, but they are also more likely to have other health and social problems which affect their quality of life. For example, the most frequent victims of sexual abuse were elderly women who also had problems of orientation, ambulation, and financial problems (Teaster & Roberto, 2004). Fullmer, et al. (2005), in a study of elderly suffering from neglect, found that neglected elders were more likely to be sicker, have more limited financial resources, and have less help in the home. Strasser & Fulmer (2007) point out that neglect is one of the most frequent forms of elder mistreatment; they suggest that the mental health implications of this problem are reason for it to be given greater attention on the part of health care providers. Research also shows that elder mistreatment can lead to greater stress and higher mortality, justifying greater attention to the problem

[1] The author would like to express appreciation to the Blue Cross and Blue Shield of Michigan Foundation for providing funding for the project. Appreciation is also due to Dr. Daphne Nedd, consultant on data analysis; to Ms. Sara Rose Amberg, Research Assistant for all aspects of literature review, data recording and analysis; to consultants Rachel Richards of the Michigan Adult Protective Services Department, Cynthia Farrell of the Michigan Department of Human Services, and Lynne McCollum of the Michigan Office of Services to the Aging for providing the resources of their agencies; to the Institute of Gerontology at Wayne State University, particularly Dr. Peter Lichterberg and Dr. Mary Kay Cresci for support and advice; to Dr. Rochelle Zaranek, who conducted the first phase of interviews; and to Edyta Debowska, Rose Freigeh, Jamie MacCardle, and Paige Wilkinson, students in the Wayne State University Honors Program, who provided assistance with interviewing and transcribing of interviews. Finally, deepest appreciation is due to the focus group respondents who gave of their time to provide input to the project; without their assistance the project would have been impossible. All responsibility for data interpretation remains the responsibility of the author.

(Baker, 2007). Clearly, these are problems in need of serious attention on the part of society.

The most commonly used method of dealing with elder abuse is mandatory reporting, which requires members of certain professions who work with the elderly to report suspected cases of elder abuse to an official agency of the state. This is the approach used in the State of Michigan. However, this approach is largely dependent upon the level of knowledge and willingness of the mandated reporters to comply with the state requirement. Some researchers have found that mandatory reporters are often lacking in either knowledge or willingness, or both. For example, one study evaluated the level of knowledge of health care providers, both in and outside of hospitals; he found that many were aware of elder abuse and neglect and able to recognize it, but he believed training was necessary to insure that these workers are knowledgeable and aware of their legal reporting responsibilities (Rinker, 2007). Hence mandatory reporting requires a high level of skill and dedication on the part of reporters.

A major category of mandatory reporters are physicians. Research raises considerable question concerning the value of physicians in this regard. One study found that primary care physicians had little knowledge of elder abuse or how to deal with it; only half had ever identified a case, and nearly three-fourths reported no exposure to the problem (Kennedy, 2004). Not only were physicians unaware of elder abuse, but many were also unwilling to conform to mandatory reporting requirements. Rodriguez, et al. (2006) found that physicians felt that mandatory reporting led to a change in patient-doctor rapport, lower quality of life for the patient, and diminished physician control of the case, leading to their reluctance to report abuse. If physicians are to be mandated reporters, consistent training and motivation programs are likely to be needed to insure their involvement. This is very likely true of other professions as well.

Mandatory reporting is also dependent upon the effectiveness of the mechanisms used to detect abuse. Some authorities recommend that multiple measures be used by reporters. Cohen, et al. (2007) analyzed three methods for assessing abuse: direct questions, search for physical evidence, and assessment of risk; they found that all three measures are critical to effective detection. A 27 item scale to identify older people at high risk of abuse was developed and tested by Cohen, et al. (2006). The measure included characteristics of both the elder and his or her caregivers. The authors recommend using such an instrument to improve identification. In a study of care planning for veterans, a functional assessment system was recommended for use with patients in home care; the format recommended a number of issues, such as adequate leadership and training, adequate assessment, appropriate planning and resources, be included (Hawes, et al., 2007). Again, constant attention to the identification mechanism is needed.

Some research has noted that the problem of elder abuse is a notoriously intractable problem. Established methods for dealing with other problems have not been effective in dealing with elder abuse. These cases tend to be more complex, with characteristics of both victim and offender needing attention (Ramsey-Klawsnik, 2000).

Some researchers have recommended the development of innovative programs to deal with this problem. Mosqueda, et al. (2004) report on a "Vulnerable Adult Specialist Team" (VAST), which brings together a variety of experts to consult with APS and criminal justice agencies on the kinds of injuries, both physical and psychological, which were exhibited by victims of abuse. They found this program helpful, both in providing the APS and criminal justice agencies with medical expertise, and providing the physicians and psychologists with greater knowledge of elder abuse and APS procedures. Similarly, Wiglesworth, et al. (2006) found that an "Elder Abuse Forensic Center" (EAFC), which brought together professionals from a variety of disciplines to handle the problem of elder abuse, lead to the development of interagency liaisons, increased collaboration and cooperation, and contributed to more effective management of the problem. Holkup, et al. (2007), also suggest that elder abuse prevention is more effective when the programs are community based and involve families in all aspects of the screening, referral, and service provision processes.

All of these studies suggest that constant oversight of the process for dealing with elder abuse is needed to insure that the best approaches are being employed. Well motivated and knowledgeable reporters; effective tools for identification; adequate staff to perform the investigations; and the support of the community for the program are all necessary to bring about a solution to this difficult problem. It is towards this end that we undertook a review of the Elder Abuse Identification and Intervention Program in the State of Michigan.

METHODOLOGY:

Planned Methodology:

The goals and objectives of this project were to be achieved through the collection of both quantitative and qualitative data. The quantitative data to be collected included data on reported cases of abuse, neglect, and endangerment, collected by the Michigan Department of Human Services Adult Protective Services Department during the period covered by the project. These data were to be employed to determine the kinds of cases which were being reported to the State; the types of abuse, neglect, and endangerment likely to be reported; the character of the reporters, that is, what types of professionals were likely to report abuse; and the likelihood that cases can be substantiated, or determined to be reliable reports of actual abuse.

Qualitative data were the most critical component of the project. These data were needed to determine the effectiveness of the current system of reporting and evaluating elder abuse cases in the State. Two methods of collecting the data were planned. First, officials from the Michigan Department of Human Services, the Adult Protective Services Department, and the Michigan Office of Services to the Aging were to be used as consultants to the project. Second, focus groups were to be held with representatives of three to six agencies which are likely to observe abuse of the elderly, for the purpose of determining their opinions as to the effectiveness of the State's elder abuse detection and assistance measures.

Focus groups were to be held at two points. The first interviews were to be held at the outset of the project, to determine the participants' views of the existing state of elder abuse identification and assistance. These data were to be analyzed to determine the effectiveness of the program. Once these data had been analyzed, a second set of focus group interviews was to be held to present the findings of the evaluation, to suggest alternative models, and obtain the participants' views concerning their feasibility.

In order to maximize the feasibility of data collection, the project was to include only the tri-county Detroit Metropolitan Area. Hence only cases from Macomb, Oakland, and Wayne counties were included in the quantitative data. And only professionals in agencies located in these three counties were included in the focus group interviews. Obviously, this limits degree to which project findings can be applied to outstate areas. Whether our findings are applicable to the rural outstate counties or to the smaller cities outstate is not known. However, it should also be noted that these three counties constitute the most populous area of the State, as well as the majority of reports of abuse and neglect of the elderly.

Actual Data Collection:

Once the project began, it was obvious that some changes in the methodology were required. Changes in the State of Michigan's structure for the relevant departments made it difficult for the departmental executives to serve as consultants in the manner planned. This also made it more difficult to obtain the required quantitative data.

Two corrections were made in the project in order to deal with these problems. Data to be obtained from the State level consultants were replaced in two ways. The first was the use of the *Michigan State Governor's Task Force on Elder Abuse Final Report* (2006), which was disseminated in summer, 2006, shortly after the initiation of the project. This document (hereafter known as *Task Force Report*) provides a description of the goals and objectives of the State's elder abuse assistance program. Second, in order to obtain information on the manner in which the State collected and manages elder abuse cases, consultants at the State level were supplemented by focus groups with Adult Protective Services agencies at the local level.

Quantitative data were eventually obtained at two points in time. One data set included cases reported to the State during the months of June and July in 2006. The second data set was comprised of cases which were reported to the State during February and March, 2007.

THE MICHIGAN ELDER ABUSE MODEL AS COMPARED WITH THOSE OF OTHER STATES:

Analysis of the State's Goals and Objectives:

We now move to an analysis of the State of Michigan's goals for its adult protective services Department. For this section of the report, we depend upon two documents. The first is the State of Michigan Adult Protective Services Law, as summarized in Richards (2006). The second is the *Task Force Report* (2006).

Michigan's Adult Protective Services law aims to protect "vulnerable adults" from abuse, neglect, or exploitation. A vulnerable adult is defined as a person over the age of 18, "Who has a condition in which said person is unable to protect himself or herself from abuse, neglect or exploitation because of a mental or physical impairment or because of advanced age" (Richards, 2006: 5). According to Michigan APS law, a person is eligible for services under the APS law if, and only if, four conditions are met. These conditions are: the individual is 18 years of age or older; the individual is "vulnerable," as defined above; the individual is at risk of "harm (abuse, neglect, exploitation)"; and there is a "Reasonable belief that the individual is a vulnerable adult in need of protection" (Richards, 2006: 9). Four types of maltreatment are included in the Michigan APS law:

> **Abuse** Harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes non-accidental physical, mental or sexual abuse.
> **Neglect** Harm to an adult's health or welfare caused by an inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare. (failure to provide adequate food, clothing, shelter, medical care, etc.).
> **Self-Neglect** Behavior by an adult that threatens his or her own health and safety.
> **Exploitation** An action involving the misuse of an adult's funds, property or personal dignity by another person (Richards, 2006: 6).

Hence these four types are all included in the Michigan elder abuse law. Common terminology makes use of the term, "abuse," to refer both to the specific category of abuse defined above, as well as in a the broader sense, to refer to the entire class of abusive actions, including all of the above. Throughout this work, we will use the term, "abuse," in both of these senses.

The major component of the Michigan APS law is its requirement of "mandatory reporting." That is, it requires that certain classifications of employees report to the designated State agency (i.e., the APS Department) any cases in which abuse, neglect, self-neglect, or exploitation of vulnerable adults, as defined above, is suspected. The law defines "Mandated Reporters" as "Those employed, licensed, registered or certified to provide or who are employees of an agency licensed to provide: a. Health Care; b. Education Services; c. Social Welfare Services; d. Mental Health Services; e. Other Human Services; Law Enforcement Officers; Employees of the County Medical Examiner; Physicians" (Richards, 2006: 7).

Review of Elder Abuse Models:

Numerous models for the identification and assistance of abused elders have been used in the United States since elder abuse was first recognized a problem in approximately 1970. By the 1990s, all states had laws requiring some type of approach to dealing with this problem. This diversity of approaches has lead to the development of a wide variety of models for approaching the problem.

Nerenberg (2008: Chap. 3) has provided a valuable summary of the various models for managing elder abuse. She lists eight different approaches which are

commonly used. While I am indebted to the author for her summaries of these models, the commentaries are the responsibility of this author.

The Adult Protective Services Model (APS), also referred to as "Mandatory Reporting," requires the reporting of suspected cases of abuse or neglect by professionals who serve the elderly or otherwise vulnerable adults. This model is based on the model for Child Protective Services (CPS) which has been in operation for a longer time. A major difference between APS and CPS, however, is that services in cases of child abuse are imposed, while services to abused adults are always voluntary, based on the assumption that if elderly victims of abuse or neglect are mentally competent, they have the right to refuse services if they wish.

The Domestic Violence Protection Model is based on the approach which has long been taken with victims of intimate partner abuse. This model tries to avoid viewing the victim of abuse as a "victim," preferring to focus its attention on empowering victims: encouraging them to become more independent, to "stand up" to their abusers and resist abuse. This approach is particularly focused on encouraging victims to take legal action. Since it is drawn from work with domestic violence victims, a majority of whom are women, it also tends to focus on gender issues which might be present.

The Public Health Model is drawn from the experiences of the health professions in responding to and controlling the spread of disease. The central component of this model is prevention. Consequently, this model tends to focus on the factors which place a person at risk for the particular condition. In applying the model to elder abuse, it calls for identifying the factors which place elders at risk for abuse or neglect, determining which populations of the elderly are more likely to be at risk, and taking measures to place them at less risk. For example, this approach would suggest separating elderly parents from relatives, such as children who are addicted to drugs or alcohol, who might be likely to abuse them. It would also suggest that caregivers be provided with respite care to prevent their becoming over-stressed and more likely to abuse those in their care.

The Victim Advocacy Model is drawn from theories and research on victimology, which first became part of the literature on criminology in the 1940s. This approach has tended to focus on the rights of victims in the criminal justice process: their need to have revenge and/or restitution as a result of the grievances they have suffered, and the desirability of the criminal justice system providing options for input from the victim in dealing with offenders.

The Restorative Justice Model is also based on a criminal justice model. However, it goes further than the Victim Advocacy Model in suggesting a way for this type of reparation process to occur. The restorative justice model has suggested, for example, that victim-offender mediation occur in order for the offender to observe how the victim has been injured, and the victim have an opportunity to confront offenders, either their own offender or offenders in general, and gain some remuneration for their injury. In the case of elder abuse, proponents of this model suggest problematic issues,

such as guardianship or residential moves for the elderly, could benefit from family conferences or other mediation processes.

The Neutralization Model is drawn from criminology, and focuses on the motivations of the offender. This model suggests that the reason offenders engage in their deviant acts is that they believe they are justified. They "neutralize" the impact of societal rules on their behavior by pointing to the unfairness of their situation and/or the greater advantage which their victims may possess. This perceived unfairness excuses them from following community rules. Community agencies, such as the courts and the legal system, aid in this neutralization process by giving light or suspended sentences or dismissing the cases against offenders.

The Family Caregiver Support Model largely draws from the experience of medical and social work personnel who deal with elderly patients and their caregivers. Noting the severe stress which caregivers can experience, they advocate caregiver training, financial assistance, and respite care, to provide caregivers with occasional relief from their duties. This model is effective in cases in which caregiver stress is indeed the cause of the abuse. If, however, other factors, such as drug or alcohol addiction or aggressive tendencies are present, this model may not be appropriate.

The Family Preservation Model, like the Adult Protective Services model, is based on experience with abused and neglected children. Several programs have been developed to work with families who have lost or may lose custody of their children as a result of abuse and/or neglect. These programs tend to assign workers small case loads, and employ counseling, child development training, financial aid, and other types of assistance to parents, to help them become more effective parents and diminish the likelihood of abuse and neglect. Elder abuse programs which follow this model attempt to apply the same techniques to working with the elderly and their families.

As noted above, the most commonly used approach, and the one used in Michigan, is the Adult Protective Services Model. It should be noted that some of these models may conflict with each other. For example, the Domestic Violence Protection Model seeks to empower victims of family violence, and recommends that victims leave the abuser, while the Family Preservation Model attempts to keep families together. Similarly, the Victim Advocacy and Restorative Justice Models both attempt to provide the victim with a sense of satisfaction that their grievances have been heard and dealt with; however, these approaches both may make it difficult to preserve family bonds, a goal of the Family Preservation Model.

EVALUATION OF THE MICHIGAN MODEL:

We now move to an analysis of the objectives of the Michigan Adult Protective Services system. What do the responsible governmental agencies, the Michigan Office of Services to the Aging, and the Department of Human Services, aim to accomplish by means of the program for the protective services for older adults and other vulnerable adults? For information on the Michigan program, we turn to documents from the Adult

Protective Services Department, as well as the *Final Report of the Governor's Task Force on Elder Abuse* (2006).

The model which the State of Michigan uses for identifying and providing services to abused adults is primarily the Adult Protective Services model, as described above. Professionals who work with the elderly or other vulnerable adults are mandated to report to the official state agency, the Adult Protective Services Department of the Michigan Department of Human Services. Mandated reporters are provided with immunity from prosecution if they report in good faith (Richards, 2006).

Michigan also includes elements of some other models as well. For example, the Public Health Model, as described above, is often used in training programs to instruct mandated reporters in the methods for recognizing risk factors which may be useful in identifying victims of abuse or neglect. The Family Caregiver Support Model is used for suggesting approaches to caregivers to help them decrease the stress of caring for dependent elders. The Family Preservation Model may also be used in some instances, to provide services to victims and their families; however, it is rarely with the depth and breadth of services provided to children and their families. The Domestic Violence Protection Model, Victim Advocacy Model, Restorative Justice Model, and Neutralization Model are rarely used in Michigan, as well as in most states. Indeed, the absence of some of these models was noted in the *Task Force Report* (2006).

In our analysis of the effectiveness of the Michigan model, we will begin with an analysis of the *Task Force Report* (2006) mentioned above. This will be followed by an analysis of the quantitative data, and finally, a description of the findings from the qualitative interviews with professionals in the agencies interviewed.

Final Report of the Governor's Task Force on Elder Abuse (2006):

In its overall analysis of the management of elder abuse in Michigan, the Task Force found that there was a need for a "…more cohesive, coordinated, and proactive response…" to the problem. Particularly important was the observation that self-neglect was the type of harm which was most frequently substantiated; this was followed by neglect and financial abuse. The Task Force recommended special attention to these areas (*Task Force Report*, Section 5-2).

To deal with the challenges they observed, the Task Force recommended several policy changes. These included: creating a single agency to serve as a "focal point" for coordinating efforts at preventing, treating, investigating, and prosecuting elder abuse, as well as raising public awareness of the problem; promoting assistance to families and caregivers to prevent abuse; making it more difficult for financial documents to be used to commit abuse; removing barriers to reporting abuse in health care settings as well as financial institutions; enhancing investigation through the development of teams of key players; and changing laws to prosecute abuser more effectively. The Task Force made special mention of the need to integrate reporting systems, as well as provide special training to law enforcement officials and prosecutors. It also recommended changes in

the law to improve the prosecution of abusers and make the sentencing more appropriate to the crime (*Task Force Report*, 2006: 2-4; quote at pg. 4).

The Task Force focused on six special categories of problems faced by the State. Public awareness of the fact that adult abuse is a crime was a particular problem which they found needed attention; they recommended an extensive campaign to increase awareness, with a specific agency responsible (*Task Force Report*, 2006: Section 1).

Preventing physical abuse, psychological abuse, and neglect were also targeted. In particular, they stressed the need for special protection for incapacitated persons, caregiver support, respite services, improvement of home health services, and improvement of guardianship and conservatorship regulations, which had already been recommended by the Michigan Supreme Court in 1998. It also urged improving the participation of health professionals in the identification of abuse (*Task Force Report*, 2006: Section 2).

Financial Exploitation was described as an area in need of major attention. Preventing false claims and fraud against the elderly, and preventing abusers from inheriting from their victims, were examples of serious needs. Obtaining the assistance of financial institutions, and using licensing laws to enforce conformity to professional regulations were seen as a major mechanism for achieving improvement in this area. The Task Force considered this area so important that 16 separate recommendations were made in this area, the largest number for any category (*Task Force Report*, 2006: Section 3).

The Task Force also noted some problems with the reporting process. In particular, they urged requiring nursing home employees to report directly to the State, rather than reporting through their supervisors, as well as making financial institution employees mandated reporters. Improved training for persons who work with vulnerable adults was also recommended (*Task Force Report*, 2006: Section 4).

Investigation also came in for more serious attention. The Task Force recommended the creation of a Special Prosecutor Program for abuse of the elderly, with specially trained multi-disciplinary investigation teams and expert witnesses. They also recommended more training for criminal justice and public safety officers, and mandatory reporting of deaths in facilities which care for vulnerable adults. An important recommendation in this area was an increase in the number of Adult Protective Services caseworkers (*Task Force Report*, 2006: Section 5).

The prosecution of abusers was the final area which the Task Force believed required special attention. They believed that sentencing guidelines should allow for increased maximum penalties in elder abuse crimes, and urge that judges be allowed to order consecutive, as opposed to concurrent sentences, on offenders who prey on multiple victims. Increased penalties were also urged for wrongful death in certain types of care facilities, for obstructing the investigation of adult care facilities, and for other crimes which prey on the elderly. Altering court proceedings so as to make them more

hospitable to elderly victims was also recommended. All of these recommendations, as well as some in other sections, would require action by the legislature and State administrators (*Task Force Report*, 2006: Section 6).

To summarize, major elements of the Task Force recommendations were the need for more coordination of efforts to deal with elder abuse, or what the Task Force called a "focal point" to coordinate elder abuse prevention activities in the State. They also called for more emphasis on the most frequent types of abuse (neglect, self-neglect, and financial maltreatment), including the necessity of changes in law and policy in these areas. They also recommended that more case workers be hired by the Adult Protective Services Department to handle these important cases.

Quantitative Data Analysis:

Data on the cases of abuse, neglect, or maltreatment of elderly or other vulnerable adults to the Michigan State Department of Human Services Adult Protective Services Department (APS) were obtained for two points in time during the period of the project. Since there have been suggestions that different times of the year produce more cases of violence in the family, it was thought that obtaining data at two different points in time might be preferable to a examining a single reporting point.

The two points provided were Summer, 2006, which included the months of June and July, and Winter, 2007, which included the months of February and March. As indicated earlier, only data for Macomb, Oakland, and Wayne counties were included in the analysis. The reader should be aware that this project counted reports in a different manner from the State of Michigan. The State records a "case" when a report of any type of abuse is submitted. Using this method of counting cases, several reports will be recorded for a single individual if more than one type of abuse is observed. For the purposes of this study, we wished to analyze individual persons who were victims. Consequently, we converted all reports to individual cases, and added a separate category for those cases which involved "Multiple Abuse." Hence the numbers of cases recorded will be different from those which appear in the Michigan records.

Table 1 provides a summary of the reports which were presented during these two time periods. As indicated in the table, the largest percentage of cases (57.1%) were reported in Wayne County; Oakland County was second, with 28.6% of the cases; and Macomb County was third, with 14.3% of the cases reported. This case differential is to be expected, given the relative size of the three counties. The data indicate that the number of reports for the two periods was approximately equal (102 during the summer period, 108 in the winter period). In four-fifth of the cases, APS workers were able to substantiate that abuse had indeed occurred. Slightly more cases reported in Summer, 2006, were substantiated (84.3%), as opposed to those reported during the Winter, 2007, period (75.9%). However, the differences are small.

A major concern of the project was to determine whether the APS model works well with the various types of professionals who may encounter elderly victims of abuse or neglect. Hence an analysis of the types of workers who reported cases to APS during

the periods in question is in order. Since there appeared to be little difference between the two periods or the different counties involved, aggregate data have been used for the remaining analysis.

As Table 2 shows, health care providers make the greatest number of reports of abuse by a considerable margin. Eighty-two of the 210 reported cases (39.0%) came from health care agencies. Mental health agencies and social service agencies were tied for second place, reporting 50 cases each (23.8%). Other government agencies were fourth, with 23 cases (11.4%) of cases reported. Physicians reported relatively few cases (3), which probably reflects the way in which health care agencies are structured, with social workers and nurses serving in the capacity of reporting abuse cases, and the physician him or herself reporting relatively infrequently. The State of Michigan coding system allows for "educators" and "self" as reporters. Only 1 educator reported, and there were no self-reports during the periods studied.

The reporting agencies are relatively similar in the accuracy of their reports. In each major category, approximately 80% of the reports were able to be substantiated by the APS investigators, with about 20% not being substantiated. Clearly, the health care, mental health, and social service agencies in the tri-county Detroit Metropolitan Area have familiarity with the model for dealing with adult abuse in the State of Michigan, and members of these professions make regular reports to APS concerning abuse, neglect, or maltreatment cases they suspect. However, whether these cases represent all of the cases they observe is another question. Studies have suggested that reported cases represent less than one-fifth of the cases which actually occur, and only the most obvious cases are usually reported (*NCAIS*, 1998).

Other mandated reporters appear less likely to report cases, however. There were no self reports. Only one educator reported, which is not surprising in view of the fact that it is only the rare educator who is likely to see many vulnerable adults. However, the relatively few reports from "other government" agencies are surprising. It is likely that a number of government agents, such as police and fire officials, would encounter "vulnerable adults" at risk of abuse. One wonders whether some of these cases may not be reported. The absence of reporters in the financial industries also suggests that this model may not include reporters most likely to be aware of this type of abuse. Indeed, this point was made clearly in the *Task Force Report* (2006: 2), which recommended greater attention to the identification of financial abuse.

Which types of abuse are reported most often? As the *Task Force Report* (2006) suggested, Neglect and Self-Neglect were the two most frequently reported types. Each of these types represented about 27% of the reported cases (See Table 3). Cases in which Multiple types were observed accounted for the next largest category, at about 25% of reported cases. Hence these three categories together (Neglect, Self-Neglect, and Multiple) account for more than three-fourths of the cases. Physical abuse reports constituted about 12% of the reports. This small percentage of direct physical abuse cases is interesting in view of the fact that the greatest amount of attention is usually placed on this category, largely due to the extreme character of this type of abuse.

The Task Force suggested that Financial abuse was one of the most frequent types; this was not the case in the data examined here; this type only represents about 5% of the reported cases. However, it is possible, even probable, that Financial abuse constitutes a component of a substantial number of the Multiple abuse cases. It is also likely that Financial abuse often goes unreported, as other studies have suggested (*NCAIS*, 1998). This would provide support for the Task Force's strong recommendation that Financial abuse be targeted for special attention in the State elder abuse prevention program (*Task Force Report,* 2000).

Qualitative Data Analysis – The Focus Groups:

The major evaluation of the effectiveness of the Michigan Adult Protective Services system will be based on the focus group interviews. Two types of focus groups were conducted. The private agency focus groups were conducted with professionals working in private agencies, who are mandated reporters of abuse, under the Michigan mandatory reporting law. The public agency focus groups were held with personnel working in Adult Protective Services offices in the Detroit Area, as well as with other State offices focusing on the protection of elderly abuse victims. Consultation with officials from the State offices also occurred.

As planned, focus group interviews were held in two waves. The first wave occurred between January and May, 2007. Six focus groups were in this wave, with a total of 25 participants. The second set of focus groups were held between January and April, 2008. Eight focus groups, with a total of 28 participants were held in the second wave. In total, 14 focus groups were held in eight different agencies. In some cases, the respondents in the second focus group with an agency were the same individuals as those interviewed in the first interview.

Table 4 provides a summary of the agencies with which focus groups were held, together with the number of respondents in each type of agency. In each instance, data have been summarized so as to insure the required confidentiality to the agencies and respondents. The agencies have been summarized into four types. "State agency" refers to divisions of the state government, and directly related to the agency which receives the mandated reports (APS). Five focus groups; with a total of 16 respondents, were held with State Agency workers. "Health Care" refers both to agencies which provide direct health care, such as hospitals or home nursing services, as well as to agencies which provide case managers or health care oversight. This category included the most numerous participants, with 30 respondents in 6 focus groups. "Senior centers" refers to community agencies which bring seniors together in a community setting for a variety of services. There were 3 groups with 7 individuals in this category. Senior centers also tend to bring together a broader variety of workers. Senior center respondents were more likely to include participants who were not trained social workers; some were in other fields, such as religious leaders, public safety, or other community workers.

Concerns of the Respondents Regarding the Management of Elder Abuse:

Interviews clearly indicated that the service providers had numerous concerns about the manner in which elder abuse is handled in Michigan. This is true whether the respondents were employed by the State agencies or in the private agencies which were making the reports. In the following section, we will begin by analyzing the concerns of the Adult Protective Services officials and workers in the State of Michigan. This will be followed by an analysis of the perspective of the workers in the other agencies, which are largely private. They represent the mandated reporters whose input is necessary for the mandatory reporting system to be effective. Following these two analyses, we will conclude with a comparison of the similarities and differences between their two perspectives, and attempt to reach some conclusions concerning possible barriers which may limit the effectiveness of the program.

Perspective of the Adult Protective Services Department:

The Adult Protective Services Department appears to have undergone several changes in structure over the years, both at the state and local levels. At times it has been managed at the city level; at other times it has been centralized at the county level, which is the current pattern. Although workers did not specifically mention this as a problem, it was clear that workers felt these changes create confusion, if not within APS, at least with some of the reporting agencies.

Mandated reports are made by telephone, and received by an intake worker, who screens the case to determine whether the client is eligible under APS regulations. As noted earlier, there are four criteria which must be met: the person is over 18 years of age; is "vulnerable" to abuse as a result of age or a physical or mental condition; is "at risk" of harm; and there is a "reasonable belief" that this person is "in need of protection." Included in the Michigan law regarding adult abuse are some categories of younger persons, such as the developmentally disabled, who are also vulnerable, at risk of harm, and in need of protection.

The intake worker makes a decision as to whether the case fits the criteria. If it does, an investigation is initiated. In such cases, a contact must be initiated, at least by telephone, within 24 hours. This contact must be with the alleged victim or a collateral information source. It may not be with the referral source. Direct, face-to-face contact with the client must occur within 72 hours, unless the reported information suggests that a more immediate contact is necessary. A decision related to the issue of urgency is made by the APS supervisor (State A).[2]

With adult abuse cases, the information critical to initiating an investigation is greater than that for children. With children, the fact that the victim is a child provides automatic justification for State intervention. With adults, however, the State cannot intervene unless the adult is "vulnerable," as described above. That is, the adult must be incapable of defending him/herself against harm due to age or disability. Often a physician's opinion is necessary to determine whether the individual is mentally competent and capable of caring for him/herself. Criteria apparently exist for all of these

[2] The pseudonym of the agency making the statement is indicated in parenthesis following the information.

procedures; however, APS policies are more ambiguous than CPS policies, due to the fact that these other factors, such as competence and vulnerability, must be determined. Adults also have the right to refuse services if they choose to do so. APS workers are very protective of these client rights (State E).

State workers report that the information provided by reporters usually includes "medical information, hospitals, police reports … other support services…" the alleged victim receives. Hopefully they also receive names and telephone numbers of relatives, or emergency contact information (State B). They would like to receive any "… information they [agencies] could share" (State B). Particularly helpful would be information on whether someone in the family had a criminal background, but this is rarely provided (State B). They also expressed frustration that many workers are confused about their legal responsibility to report (State A). Even such vital information as the address where they can reach the client is often missing.

However, the need to obtain such information raises another issue which is critical to the reporting process: the confidentiality requirements of all the agencies involved (State D). This issue involves all agencies, but is particularly troublesome in medical institutions, which are covered by the Health Insurance Portability and Accountability Act (HIPAA), passed by Congress in 1996 (Health and Human Services, 2008). This act has made the medical professions even more wary about the appropriateness of sharing information with any other agency. This concern on the part of mandated reporters has made the reporting process more difficult. Several reporting agencies mentioned their hesitancy to share internal client information with other agencies, and APS workers noted that they had often been told this was a problem. This was the case even though the law mandates that reporting occur, and includes protections for the reporters who provide the information. In return, APS workers were also reluctant to share the results of their investigation with the reporting agencies. This confidentiality problem complicates the sharing of knowledge which could be of assistance to the abused elder. While confidentiality is clearly important, a resolution of this dilemma could improve the effectiveness of the APS process.

If the criteria are not met, the case must be rejected without an investigation. APS workers expressed frustration concerning the degree of information they receive. Often cases had to be rejected due to the fact that the reporter simply did not provide sufficient information (State D). Approximately 20 to 25 cases are rejected each month, based on the absence of adequate evidence (State A). Workers report they spend considerable effort to investigate the cases. But "… we don't always have that [information], as one worker reported" (State B). APS workers also recognize that "… a lot of people [i.e., mandated reporters] don't have the information either. … [or] that they are mandated … I really don't think these agencies really know" (State A).

Hence APS workers were frustrated that professionals in other agencies lacked information about their responsibilities as mandated reporters or the types of information they needed to provide. Most were unaware of updates in APS rules. An even greater problem occurred when agencies developed internal polices which were in conflict with

APS regulations. For example, some agencies have developed policies which require professionals to report suspected abuse to an internal screening agent, rather than reporting directly to APS. As APS workers at all levels understand the law, mandated reporters are required to report suspected abuse directly to APS. Being required to screen their suspicions with a supervisor does not conform to the law. However, some agencies have reportedly obtained legal counsel which advises them that they may do this and still be in conformity with professional requirements. APS workers see this approach as a major stumbling block to their performance of their responsibilities (State E).

It is relevant to note that state regulations do not require the use of any particular scales in the identification of elder abuse. As we noted earlier, some experts believe that identification of abuse is more effective if specific scales are employed (Cohen, et al., 2006; 2007). According to the information provided by respondents in both types of focus groups, the Michigan Child Protective Services Department (CPS) does employ a form (called a "3200" form) for use by mandated reporters of child abuse. APS workers report that reporters sometimes request such a form for adult abuse victims, and some workers thought this would be useful (State B; State D). As one worker said, "I think a more focused protocol like CPS would definitely help" (State A). However, since different information is required for adults, the same form used for CPS would not be appropriate.

Administration of Michigan's protective services makes use of different procedures, depending on where the abuse occurs. Each county has jurisdiction over abuse cases which occur within its boundaries. It also provides for a different agency to receive reports regarding cases which involve abuse occurring in state licensed institutions, such as nursing homes; in such cases, reports are to be made to the Department of Community Health (DCH) rather than APS (State B).

These differing procedures complicate the reporting process for all reporters. Reporters have to be aware of the varying procedures for each case. Different counties and divisions have different administrative procedures for reporting abuse. The three counties covered in our project all have central intake of cases, and all use a single intake telephone process for both children and adults. However, other counties may not have central intake, or may use different intake procedures for children and adults (State B). Hence reporting agencies have to be aware which county has jurisdiction in a particular client's case. Hospitals, for example, may have patients from several counties with several different reporting processes. And incidents in nursing homes will require different procedures, depending on whether the alleged abuser is an employee or a visitor. Seasoned professionals who observe adult abuse on a regular basis are probably aware of these varying requirements. However, this variation could make reporting difficult for workers who observe only an occasional instance of adult abuse.

APS workers also complained that many other agencies do not understand what APS can and cannot do. They expect a great more than APS is has authority to do. "We are not a placement agency. We are not discharge planners. … there's a lot of things … that people look to us for. … we [must] come to court to get guardianship, to get the

authority to go into the home to protect [the clients] (State A). When their performance does not meet with the other agencies' expectations, the other agencies complain: "… [the other worker] looked right at me and said, 'Well what good is APS then?'" (State A). Clearly, the role of APS, together with the limitations of its authority, is not understood by many other agencies.

This lack of knowledge about the APS role is shared by other government agencies as well, including such agencies as the Michigan Department of Community Health, police, and courts. Several APS workers reported having difficulty with other government agencies with which they must interact in order to serve their clients effectively. Guardianships appear to be a particularly vexing problem. These are critical because often they are needed for dependent older adults, and only a court can make the decisions related to the guardian. However, APS workers report that court officials often make their lives difficult by not performing the simplest of tasks, such as reminding a guardian about their regular reports, and referring all problematic issues to APS.

APS workers also complained about state appointed guardians or conservators who do not do their jobs or do them inadequately, leaving dependent elders at risk. Efforts to exhort court officials to replace noncompliant guardians were largely unproductive (State A). Constant delays in assigning a date for court appearances also cause time-consuming delays in APS work. One APS agency reported having had extensive negotiations with the chief judge in the local court to establish a more efficient procedure for assignment of cases. However, when workers tried to implement these procedures, lower level court personnel informed them they knew of no such agreement. Either the altered procedures had not been communicated to line personnel, or line workers had not bothered to implement them. In general, APS workers perceived "…a sort of, a lack of respect for the workers sometimes, and their ability and knowledge, from the court" (State A). Hence APS work is less effective than it could be, due to actions of agencies outside of APS workers' control.

A serious concern for personnel who deal with elder abuse is the need to identify persons who have abused or neglected older adults in the past, so as to prevent their continuing in positions with access to vulnerable adults. An obvious answer to this problem is the existence of a central registry of previous offenders, similar to that which exists for persons who have abused children. Some APS workers indicated that such a registry is one of their long standing objectives. One worker said, "… there'd better be some sort of central registry, too. That would be a huge thing." However, a colleague immediate commented: "Well, there won't be, because it is very expensive to maintain" (State A). In general, APS workers at every level complained that their input regarding the needs of elderly victims or possible improvements in agency policy or procedures were rarely considered, or even requested.

The differential manner in which adult and child cases are handled was also frustrating to APS workers (State E). Indeed, this issue was mentioned by nearly every agency interviewed, both public and private. All perceived the needs of adults to be

considered of lesser importance than those of children by representatives at nearly every level of government. One worker said:

> It's sort of like children's things get in the newspaper more, and there's more ombudsmen, and child advocates, and there's more oversight and we're always answering to people about those cases. But I noticed with APS, it just kind of, is off in the background. Even the person at central, who the [APS] program is under … she'll say to me, "I don't have any time for APS. I never do" (State A).

Workers viewed the absence of a state registry as another symptom of the lower priority assigned to adult cases. Such patterns appeared at every turn, even when they believed they had achieved an objective. One worker described an extended effort of their agency to obtain assistance from a legal agency for APS cases. The agency finally assigned an attorney to work with APS. The worker describes the attorney's first meeting with the staff:

> I guess we have like a gentlemen's agreement that they are going to be backing us up, but when he came in to talk with us, he told us and I believed him, "My first love is children. Adults is way down here." So, they don't have the knowledge base. They don't really know the population. They don't know about vulnerability, risk, what's going on out there. And basically, said, "Children come before adults. We are going to deal with the children. That's where the love is (State A).

APS relations with hospitals were viewed as particularly troublesome. APS workers viewed some hospitals as using APS as a mechanism for avoiding some annoying dimensions of case management. Guardianship was one such issue. Some hospitals were thought to be referring patients who needed guardians to APS, allowing the hospital to avoid the time involved in going to court, as well as transferring the court application fee to APS. They also complained that discharge planners sometimes called APS late in the patient's stay in order to avoid the problem of returning a patient to an unsafe environment. However, many of these cases were not appropriate APS referrals, and those which were appropriate were referred too late. Even more annoying was the fact that the hospitals had extensive patient information, but the referrals often lacked the information necessary to determine whether it was an appropriate APS case. When APS rejected such cases, the referring agency would complain that APS was not doing its job (State A). APS workers viewed such agencies as "dumping" their difficult cases on APS.

Training for their jobs was another issue which APS workers found problematic. Training was described as "very minimal" (State A). Cases which involve determinations of mental competency are particularly vexing, but APS training provides no background in this issue. APS workers depend upon mental health personnel or physicians to provide this input. However, many physicians are reluctant to testify in court regarding mental competency cases, and collaboration with mental health workers has apparently been problematic as well (State A). Workers also felt they needed more training on financial exploitation and various legal questions. They foresaw even more serious problems as the older adult population increases. In particular, they are beginning

to see a different type of aged population appearing. One worker described the problem well:

> [Before it was] cute, little, old ladies. Now, I'm like, "God!" You're getting drug addicts. You're getting the chronic intoxication. You're getting mental illness … again, we don't have training in those areas. … many more legal areas. … who do we call if we have legal questions? … it is going to get worse as the baby boomers start aging out more. It is gonna get worse and we do not have the support. It is going to be a mess out there! (State A).

Clearly, APS workers on the line see many flaws in the process. Increased standardization of the process through a standardized form specifically geared to adults would be beneficial. Also helpful would be more APS workers to handle the workload, and additional training, both for agencies concerning the mandated reporting process, and for APS workers to provide them with skills in specialized areas, such as mental competency criteria.

Unfortunately, decisions to standardize or alter the process in any manner are policy decisions, as are any decisions concerning additional training programs. This is true both for APS workers and for personnel in mandated reporting agencies. All policy decisions are made "… through legislation really in Lansing. Our job really is dictated by law and so we really have no discretion to change policy. It's the legislators" (State B). Furthermore, APS workers made it clear that workers at the local level are not involved in the development of policy, which is "… all done through the central office in Lansing" (State B). Furthermore, all policies and procedures are implemented on the local level. Hence there will be considerable variation in the amount and types of training provided, the degree of collaboration achieved, and so on, for the various county APS units. This will also affect the degree of cooperation they are able to develop with local private and public agencies (State D).

Finally, staffing is a critical issue to consider regarding the effective conduct of protective services for vulnerable adults. APS work is an extremely work-intensive process. As one agency worker commented: "Nothing makes up for staff, nothing like machines, [for] combing your [i.e., a patient's] hair and wiping your butt" (Health D). All APS work involves a considerable amount of time on the part of highly skilled workers in variety of agencies and at several levels. Reporting agencies invest considerable time and effort into observing symptoms and making reports. Once a report is received, APS workers must invest a great deal of time in examining the reports presented, evaluating the information presented, and determining whether abuse has occurred, and recommending further action.

However, staffing levels for adult services in Michigan have been diminished by nearly half in the past eleven years, from a total of 649 adult services workers in 1998, to 328 in 2006. It remains at that level in 2008, with little indication this will change in the near future (See Table 5). Note that these numbers include *all* adult services workers, not just those dedicated to APS work. As a result, all adult services workers are extremely overburdened. And APS workers represent only a portion of those 328 adult workers.

One county APS director estimated investigating approximately 50-60 cases per month or 800-900 incidents each year (State A). Another county APS unit estimated that its workers each handled approximately 25 active cases at any given time, quite a high case load for demanding cases such as these (State D). Commenting on the amount of funding APS has received, one State worker commented:

> you say you want to keep 100 workers doing APS … statewide, that's statewide. So that's 100 workers for those 16,000 referrals we're getting in a year. That's not enough staff to cover those referrals (State E).

When presenting these data in a pubic setting, I was confronted by a questioner who believed that computerization was the answer to this problem. As indicated above, the view that the identification and assistance to aged abuse victims can be reduced to a computerized process makes as much sense as allowing an unguided robot to perform brain surgery. Management of APS cases is a labor intensive process requiring sophisticated professional judgment. It cannot be computerized or relegated to unskilled workers. Nor can the amount of time devoted to a case be diminished by much.

To summarize, APS workers noted a number of problems with implementation of the State's program for the management of adult abuse. These difficulties made an already difficult task of assisting elderly victims even more trying. These problems involved the responses of mandated reporting agencies, other government agencies, APS's own policies and procedures, and the changing characteristics of the aging population as a whole.

With regard to the reports they receive, reporting agencies did not provide APS with sufficient information to determine whether some cases could be accepted. In others, the information provided was insufficient to conduct an effective investigation. APS workers complained that many mandated reporters were not aware of updates in APS regulations, and many agencies developed their own reporting procedures, some of them in conflict with State legal requirements. APS workers also perceived some agencies as using APS as a "dumping ground" for cases which the agencies themselves did not want to handle.

Workers were also frustrated by problems within APS itself, as well as with other unit of State and local government which failed to provide the resources they felt they needed to do their jobs effectively. Local courts and legal authorities did not respond to the needs of vulnerable adults in a timely manner. Court appointed guardians continued to be paid for their work while doing little or nothing for their wards, and the court did nothing. They believed that certain procedural changes, such as the development of a standardized form and a registry of persons with a record of abuse, might improve APS effectiveness. They were aware that there were areas in which they needed additional training, particularly in the areas of mental diagnoses, financial abuse, or legal issues. They knew their case loads were exceptionally high, and were likely to get worse, with the predicted increase in size and character of the elderly population.

Finally, APS workers perceived officials at the State level to be unresponsive to their concerns. They felt that many changes were needed in the system, but were aware that these could only be accomplished through legislative action. Finally, they had no hope that these concerns would even be recognized, much less enacted, particularly as many officials had made it clear that the needs of older adults fell far below those of children in the priority list. What was striking, however, was the high degree of commitment which characterized all workers interviewed in the State agencies. As one worker said, "Yeah we get cynical, but … I think every single one of your APS workers, we love what we do" (State A).

Reporting Agency Point of View:

We turn now to an analysis of the perspective of workers whose professional status obliges them to report suspected cases of adult abuse to the APS agency. What is their view of the process? Are the policies and procedures clear and understandable? Is the reporting process easy to use? What is their relationship with the APS units with which they must interact in order to comply with the mandatory reporting requirements? How are the reporting requirements viewed within their agencies? Are there any changes they would suggest in either setting to improve assistance to abuse victims?

As noted earlier, focus groups were conducted in several different types of reporting agencies. We have divided these agencies into two categories. One category included agencies which provided "health services." For the purpose of this study, "health services" included any agency which provided a service in which medical care, either curative or palliative, was a major part of the agency's work. This could include hospitals, physician's offices, home nursing services, case management or oversight services, and the like. Six focus groups were conducted in agencies of this type. The other three focus groups were held in senior centers. While these agencies occasionally provided health services, such as assisting seniors who were hospitalized or taking them to doctors' offices, these were a minor part of their service, which was much more focused on other aspects of seniors' lives. As we will see, the two types of agencies took a very different perspective in their approach to APS reporting.

As we noted earlier, reports of suspected abuse to APS must include a considerable amount of information in order for APS to make a determination of eligibility. Absent such information, an investigation will not even begin. This requirement posed a dilemma for some reporting agencies, who might find it difficult to obtain the required information. There is a major difference in the points of view of these agencies, with APS, the health agencies, and the senior centers, each taking quite a different approach. Four major categories of concerns were raised. These were problems of the setting, inadequate access to information, time limitations for adequate investigation, and internal agency problems of various kinds. We will discuss each of these problems in turn.

The critical nature of the setting was an important factor in determining whether sufficient information could be provided to the APS. Agency respondents took care to distinguish between the types of settings in which possible victims of adult abuse were

observed. Where agency personnel had long-term, ongoing relations with clients or patients, more information was available. If persons were seen as inpatients in a hospital, a considerable amount of information could be accumulated (Health C). Workers could visit several times, if necessary, and learn the various dimensions of the problem. Similarly, agencies which conducted home visits could often obtain a considerable amount of information about the alleged victim, as well as family characteristics which might impact on the situation.

Transitory settings were much more problematic. If a patient was seen only briefly in the emergency room and then released, this would provide little opportunity for workers to obtain all the information APS regulations required (Health C). Community settings, such as a senior center, offered even less opportunity to observe all relevant information about suspected elder abuse (Health C; Center A, B, C). If elders are seen only briefly at a senior center "Food and Friendship" luncheon, this offers little opportunity for workers to notice if they exhibit symptoms of abuse or neglect.

Even when the time available offers considerable opportunity to observe an elder, workers responsible for reporting often see only a fraction of suspicious cases. In many health settings, there is a fairly clear division of labor among staff in the area of adult abuse. Hospitals, for example, tend to assume that hospital social workers are responsible for responding to cases of elder abuse (Health C). Indeed, there is often a two-tier approach to training in adult abuse, with the staff as a whole receiving a very general introduction to the problem. Direct contact with abuse cases, and training in their management, is limited to certain specified staff, usually social workers or nurses. Only they become expert knowledge in dealing with suspicious cases.

As a result, the most knowledgeable workers often saw only a fraction of possible abuse cases. Some suspected that many other cases were never brought to their attention because the physicians and nurses who observed the patients missed the critical signs, particularly in more subtle cases such as self-neglect or exploitation. They feared that many cases are "… just missed by the physicians…, [who are] just looking at the more blatant and not more subtle cases…" (Health C). In particular, workers worried that symptoms of the abuse types which medical personnel are not used to seeing would be very likely to be missed. Emotional abuse, neglect, and financial abuse were those they considered to be most frequent, followed by physical abuse (Health C). But symptoms of financial or emotional abuse were less likely to be recognized, and would not be seen by the social workers who knew the reporting process. Again, they were confirming the concerns of the *Task Force Report* (2006) that cases such as financial abuse or neglect were commonly missed in the mandatory reporting process.

Workers also noted that they often needed information on the family situation in order to determine whether a client was at risk. Again, the most knowledgeable workers often did not receive this information (Health C). Even when a case was referred for possible reporting, some evidence which might have been useful to APS workers was not provided to the person who would eventually make the report. Consequently, two problems resulted. First, a number of cases which should have been reported are

probably missed. Second, even in cases which are reported in APS, some critical information was not available to be passed on to APS.

Some workers also mentioned issues related to internal agency policies which conflicted with the requirements of reporting abuse. In some agencies, workers were urged, or implicitly required, to screen their reports of suspected abuse with a supervisor or other official, rather than reporting directly to the mandated reporting agency. Most agencies interviewed felt that their own administrators were supportive of their work and allowed them the discretion to do their jobs:

> The … administration lets the department for the most part, do their jobs and their employees do their jobs because they trust them. I'm allowed to do my stuff with the seniors. I'm allowed to call [others] without calling [their bosses] (Center B).

A social worker in another agency commented: "…they [agency administrators] are quite supportive, administration-wise, and even staff on the floors (Health C).

However, this same worker noted that "… there are some doctors and nurses, who for whatever reason make their own judgments and … don't really want us involved..." (Health C). Reporters were aware that this meant that other personnel were screening reports, resulting in some cases not being reported. This was particularly likely to occur in agencies which were licensed by the State, and for which a report might result in loss of the license. One worker said, "… for us to have pressure – we don't really see that because our job is to report it. … But I never felt the pressure to not make a report" (Health D).

However, respondents in the focus groups were all fairly experienced professionals who had attained a degree of stability in their positions. They would be aware of the seriousness of the issues, and have sufficient seniority to withstand outside pressure. One can imagine, however, that relatively young, inexperienced workers could easily be intimidated into allowing a superior to handle these reports for them. Respondents were aware of these problems (Health C, E). A somewhat more subtle dimension of this pressure was the urging on the part of superiors or other officials to evaluate the seriousness of a case prior to making a report. Some workers had suggested ways workers could provide input to their supervisors concerning troublesome situations prior to the need to make a report. As one State worker noted, some workers might think:

> … if I go outside … and report directly, … am I now jeopardizing my job because I haven't followed company protocol? … And they probably know people at their workplace that are labeled as trouble makers or something else and maybe up to being fired because they didn't follow their protocol … (State E)

Mandatory reporting requires that suspected cases of abuse be reported to the appropriate agency. It is not a matter of discretion on their part as to whether the case is "serious" enough to bring to the attention of the mandated agency. That decision should be left to workers in APS or DCH, who are particularly knowledgeable in the law and are trained to conduct these investigations. However, some agencies, particularly hospitals, have sought legal advice from their institutional attorneys in this regard, and claim that

they have been assured that reporting to a supervisor is sufficient to conform to the law. APS workers insist that this is not the case (State C, D, E).

Even workers who knew the requirements well and were aware of the mandate to report sometimes did not do so. They did this for a variety of reasons. One reason was the often cumbersome nature of the reporting process. One worker explained:

> … if we can resolve it without reporting it – because by the time we report it and the State comes out to do an investigation the time elapse is so long that it's a detrimental effect to the resident. So that's why we try to mediate the circumstances to the best of our ability (Health D).

Hence workers sometimes felt that the situation could be resolved more quickly if they "negotiated" a settlement rather than moving to the official reporting process. Again, however, this also results in an undercount of the total number of cases, an issue which we raised in our analysis of the State case reports.

Some workers also reported that they did not report cases they observed at the request of the clients, many of whom were fearful of retaliation by the abuser if a report were made. This was particularly true of patients in nursing homes. Workers were aware of all types of nursing home abuse, from financial mismanagement to physical abuse or threats of abuse. Workers reported that some nursing homes required families to purchase items, such as wheelchairs and diapers, for which they are already being paid by Medicaid (Health D). Families were even afraid to have threats of direct physical abuse reported. While the mandatory reporting law protects both victim and reporter from being identified as the person who filed a complaint, workers were aware that abusers and institutions could easily determine, by a process of elimination, who was the likely complainant, and retaliate against them. If nursing home workers could not determine who had complained, they would often retaliate against other patients. Hence making a report often puts patients at risk. One worker explains:

> … a lot of families don't want to make any waves because a lot of families are afraid of retaliation. We hear that a lot of time, "don't say anything because you make it worse." So it makes our job more difficult when you have to go to an administrator and generalize the problem and not specify where the problem really is. … [Patients say] "Keep quiet don't say anything because they'll take it out on me." ... I had one resident today that told me that the CENA [Certified Nurse Assistant] told him … "If you ring that call button one more time I will come in and beat your ___" (Health D).

Hence workers have a dilemma. They are required to report, but they are aware that their reports may put patients at risk of retaliation. Like the APS workers, agency workers would like to see a roster of persons who had abused patients, so that they could not be hired to work with vulnerable elders in other settings; however, workers had little hope this would occur (Health D).

Even in the best of circumstances, the time required for the reporting process was a problem for agencies. Hospital staff reported that insurance requirements limit patient stays to such an extent that a thorough examination of possible abuse or neglect cases is

impossible. They often cannot obtain all the needed information during the few days the patient's insurance allows him/her to stay in the hospital. The cost of holding too many elder abuse or neglect cases in the hospital was a constant concern. For example, a patient exhibiting symptoms of neglect might be in the hospital. The patient could not be returned home, and could not be released to a nursing home until a guardian was appointed. Hospital representatives complained that this process was largely left up to the hospitals, and felt that APS workers could be more helpful in this regard. One agency commented on the cost in time and money:

> … It is three weeks from the time we go to court until the [hearing]. And we [the hospital] have to pay for it, and if we ask Adult Protective Services because it's a neglect type setting, they won't do it because they are considered in a safe environment. … The hospital pays $150, plus room and board for three weeks. … And an acute care bed (Health C).

Hence two concerns were the cost in time due to delays in the court and the out-of-pocket expenses the hospital had to absorb. Regarding court delays, they commented that "…depending on their roster, the court could care less." They were certain that if APS took the case to court, these problems would be alleviated: "The state doesn't pay [the court costs]. … [If] Adult Protective Services says it isn't safe, then it doesn't cost a thing." However, as indicated above, APS workers had the same complaints about cost in time and fees in their dealings with the courts.

Courts and APS were not the only government units agencies complained about. Many were generally concerned about the lack of effectiveness of many agencies serving the elderly. They felt the agencies were more concerned about receiving their monthly fees than serving the clients. Pubic guardians came in for a great deal of criticism:

> … so these public guardians with Medicaid clients are allocated $60.00 a month as a guardianship fee. … it's kind of a legal-aid agency that does guardianships and they get their lawyers assigned as the guardians. … this lady … has her own business … she's a public guardian… she groups all of her clients in one location because … if they got everybody in one location, regardless of whether or not it's feasible for your family or friends to visit you, then they can run in once a month and sign out. …nursing home people tell me … the guardian came in and signed … (Health D).

Hence some guardians were placing all their clients in one location for their own convenience. Some locations were as much as 100 miles from clients' friends and family, who could not visit or provide stimulation. Even the guardian did not actually see the patient, stopping only to sign forms. So wards never had a visit from any individual who expressed a personal interest in them. But the guardians continued to receive their fees, and agencies reported having difficulty getting courts, APS, or any other state agency to remedy the problem.

Some agency workers were also confused regarding the varying divisions within state government to which they were expected to report. Workers in agencies which

make reports on a regular basis are well aware of the regulations, and know which reports should be directed to APS, which to CPS, and which to DCH (Health A,B,D,E). However, workers in agencies which make reports less frequently are often unclear concerning the process. They know they are required to report abuse of children and some adults. However, they are uncertain as to which agency receives which reports, or how the reports are to be submitted (Health C; Center A, B, C).

Asked how they learn of APS policies, representatives of one agency were uncertain as to when they received the most recent policies. They discussed at some length their complaint that APS policies require on-line reporting of abuse cases; agency personnel thought this was an inappropriate violation of client privacy (Health C). However, this in itself is evidence of confusion. As indicated earlier, APS officials insist that it is CPS, not APS, which receives abuse reports on the internet. Workers in this agency also complained that the APS law they had received "…doesn't address [procedures for] nursing home or group home" (Health C). Furthermore, the need to report abuse in different types of agencies to different state departments creates another problem, in that they often did not know the status of the institution in which a patient lived. They might be told it was licensed, or that it was a skilled care facility; only after making a report did they learn that the home was in a different category and a different procedure was required (Health C). This wastes valuable time, both for the patient and the reporting agency. Clearly there is a considerable degree of misunderstanding within reporting agencies as to the requirements.

Agencies which report a great deal of abuse have worked with these varying requirements so frequently that they are familiar with most of the variations (Health A, B, D, E). However, many agencies see only an occasional case of adult abuse. For workers in those agencies, the rules can be daunting. They have difficulty understanding which cases should be reported to which agency. They do not understand why there is a form for CPS cases but not for APS cases (Health C). Agency reporters also complained that APS workers "do nothing" for hospitalized patients, on the grounds that the patient is "safe" at that point. APS workers insist, however, that they will investigate such cases, if there is evidence that a patient will be returned to an unsafe environment.

Agencies also complained about the lack of information they received about their cases once they reported to APS. Some complained that they sometimes did not know what had happened to their clients: "I find one of the frustrations there too, is there isn't communication while this investigation is going on. And not that they have time to call every day or anything, but it's extremely disconcerting to have a patient that … I know something is wrong at home. … I know it's not really safe" (Health C). They wanted updates to know if things were safe. One agency stated that things had improved in recent years, to the point that they now receive a letter indicating whether or not a report has been substantiated.

While they were pleased with this new development, they continued to be concerned that the information was not timely, or that the information they now received might be a phase which could change in the future (Health C). Most agencies really

wanted more detailed information (Health C; Center A, B, C). Since they often had on-going relationships with these clients, they were anxious to know if the problem had been resolved, or if further action was required on their parts. However, the only information they received was whether or not an investigation had been undertaken and if the suspected abuse was substantiated. Many agencies considered this information insufficient.

A final concern, raised by some reporting agencies, was their perception that the manner in which a case is treated depends upon the APS worker who happens to receive the report. Workers felt there was too much variation between workers in the handling of a case. As one worker said: "… about the protective service workers, I believe that … it's also subjective. Because, I have dealt with some APS workers who do jump on it, even though they are in a hospital. And meet with me and talk, and meet with the patient. It depends on who is getting the call" (Health C).

There were some areas in which the reporting agencies and APS workers were in agreement. Most important, the agencies shared APS workers' concern that issues related to adults were deemed to be less important than those of children. Two comments are illustrative:

> …when we have a baby … that it is unsafe to return home, we board the baby, no questions asked. … If it is an adult … all you hear is "When are they going?" [With] kids … they had to find emergency housing, a foster home immediately. But when you call for an adult, they just lay there in a medical bed (Health C).
>
> Um, lack of emphasis on adult abuse as opposed to child abuse where if they were children a lot of people would pay attention. Where if its adults a lot of people shrug and say they should be taking care of themselves (Center B).

As with APS workers, agency workers expressed a great deal of concern for abused and neglected elders, and a high degree of commitment to their jobs. "I love what I'm doing. I love the people," said a representative of Center C. This translated itself into a great deal of work on behalf of the elderly persons in their community, to the extent of going considerably out of their way to provide assistance. In one center, the director reported noting a problem with a guardianship agency which was misusing clients' funds. She called the agency's own corporate lawyer to take the case to court and eventually had the guardianship agency closed down (Center C). Another center representative said:

> … I think a lot of it is the community and we know our residents are our customers and we need to take care of them. … we all plan to call each other … so come on over and let's look at it … deal with the fire department … and they run on a medical … because again it's somebody we care about. …it's been open lines of communication…" (Center B).

Thus these center workers were highly committed to the welfare of their senior clients, and would go to considerable lengths to assist them.

However, these same workers had some doubts about the commitment of other workers, particularly in APS. For example, the worker in Center C who uncovered the

guardianship problem was asked if she had called APS in that instance. She responded, "I don't remember, but I had the lawyer on it. I called APS so many times you can't even remember" (Center C). Asked to explain why she would not call APS, she continues:

> You know, I had so many instances that I have reported people and stuff … [Q: Does it usually solve that case?] No, and … the only thing I got them to do was the food situation to start to serve [meals] on holidays…. [These are] individual cases. but it doesn't change the system. … And that's the hardest thing about it. You're taking care of individuals, and really, there's no change on the whole outlook on our elderly.

Her views were echoed by others. The director of one center said:

> I think it comes from the top. … I've talked to other senior directors … some other aging professionals, the frustration levels they face, the red tape. The APS workers are so understaffed and over worked. And then they have the mountains of paperwork to get someone help. We don't have mountains of paperwork. I come across somebody … and we make a phone call and worry about the paperwork later, you know. … Because I want that service (Center B).

While this director recognized the problems APS workers had, some workers were even more extreme in their criticism. This comment came from a police officer who worked with a center:

> … in my years dealing with APS it was a waste of my time and I said the same thing about CPS. They are the biggest 2 wastes of time in my world. They do nothing in my opinion. They spend more time trying to figure out about how to get out of stuff than how to get into stuff. So … one of the things I figured was that we had ways to get around it, to take care of our customers the way we need to take care of them. … In the 20 years I've been in the streets, I've never seen APS do nothing. The only time I've seen them do anything good was … one case in 20-some years. And you know, I have no use for them … And CPS, same thing. To me, they are just a waste of government money (Center B).

What is the result of this lack of confidence in APS? Some agencies simply take independent action and ignore APS completely:

> If … I'm comfortable enough I think we can handle it using our resources or referring the person [to] the appropriate resources, … then I don't call APS. If it's a situation I think the person is in desperate need or danger to themselves or someone else, then I'll call APS and hound them to death until I get them out there (Center B).

Asked how many cases they had not reported to APS, workers in this agency simply responded: "Tons" (Center B).

There is obviously confusion between APS and some agencies on a number of issues. These include the agency to which specific cases should be reported; the format of a report, whether written or oral, by phone or on the internet; the appropriateness of reports regarding hospitalized patients; and whether the response to a report will be independent of the worker who happens to handle the case. Clearly there is a credibility gap between APS and many of the mandated reporting agencies. Some reporting

agencies do not understand the process well, and lack confidence in APS ability to handle these cases correctly. These are serious problems which must be resolved if mandated reporters can be expected to report as required. If they feel a report is useless, it is difficult to motivate them to make the required reports.

As should be obvious from the preceding section, the agencies which expended considerable effort reporting cases to APS were the health agencies. Senior centers, on the other hand, tended to view APS more negatively and tended not to report cases they observed, believing they could handle them more effectively on their own. Whether or not this is true, it does result in a considerable undercount of the amount of elder abuse of various types which exists in the elderly population. Again, the concern expressed in the *Task Force Report* (2006), that abuse is underreported is confirmed.

What specific things would center workers particularly like to have the APS laws include that they felt were not there at present? Like other workers they complained about the lack of staff at APS. This resulted in delays in getting the reported cases being handled. As one center worker said, "A lot of time with APS, one call is not going to do it. Now if there's three of us calling, they're going to start listening. And it's when I start hounding them. It's not just me on the phone every 15 minutes or whatever it takes" (Center B). They also shared the APS workers' concern that they elderly population was getting larger and had different characteristics from the aged population of previous decades. Consequently, "at the same time, we're getting more elderly with more problems and fewer and fewer people to take care of them. It's kind of stupid" (Center B). Workers would also like clearer guidelines: "There's best practice for domestic violence and CPS. There's no best practices to follow for elder abuse and that's one of the issues I've seen at the local, state, and federal level. There's no mandates, there's no guidelines" (Center B).

Clearly, center workers, including the police and fire officials who worked with them, were not as aware of APS procedures, or as comfortable with them, as workers in the health-related agencies. If State officials expect workers in these agencies to be a resource in the strategy to resolve the elder abuse problem, new approaches and techniques must be employed to recruit them as active participants in the process. However, at this point, center workers are an untapped resource for identifying and assisting abused elders.

Issues Mentioned by Both APS and Reporting Agencies:

As suggested in the above discussion, a number of issues were mentioned by both APS workers and reporting agencies as problems encountered in the provision of services to abused and neglected elders. Some of these were also mentioned in the *Task Force Report* (2006). A summary of these issues of concern could assist us in determining which areas might need improvement in order to serve these clients more effectively.

Perhaps the most obvious issue on which all workers seemed to agree was the problem of serving adults as opposed to children. All workers complained that adult victims held a much lower degree of priority, from workers in a wide variety of fields,

and at all levels of government (Health C; Center B; State A; E). This resulted in all agencies having a great deal of difficulty obtaining assistance for their clients. Courts placed adult cases at lower priority. Protective services for children were given immediate attention by police, hospitals, attorneys, political leaders, and other agencies. Adults were placed on hold. There were standardized forms for use with children, making the process of identifying abuse more easily understood by individuals who were mandated to report. For adults, however, there was no such form, although many workers felt that such a form would be useful (State A). However, workers were also aware that there was little interest at any level of government in establishing such a form (State C, E).

Another common area of concern was the issue of confidentiality. Workers in all types of agencies recognized that confidentiality issues were a problem. APS workers were annoyed that they did not receive sufficient information from the reporters to determine whether a report fit the criteria for investigation. But reporting agencies, particularly hospitals and other medical groups, were hesitant to provide too much information lest they be guilty of violating confidentiality requirements, particularly under the HIPAA regulations (Health and Human Services, 2008). Once a medical agency had made a report, the issue was reversed, with the health agencies wanting more information concerning the reports they had made, and APS claiming this violated their own confidentiality requirements. A more effective process could be achieved if these confidentiality problems could be resolved.

Confidentiality was not the only communication issue which plagued the APS reporting process. Misunderstandings occurred on many issues. Many mandated reporters did not understand the reporting process. This was particularly true of agencies outside the health professions. APS has apparently been quite successful in obtaining the cooperation of the health related agencies in identifying and reporting abuse, particularly physical abuse and severe neglect. The process is not so well received by other agencies, however. The senior center agencies in our project are an example. None of the three center interviews indicated any serious effort to report elder abuse to APS, and some workers were quite skeptical that any assistance could result from APS reports.

Even agencies which were involved in making reports expressed confusion about some aspects of mandated reporting. Since reports are made to different state agencies, depending on where or by whom the abuse allegedly occurred, some agencies were confused about where they should report. Agencies also confused the CPS reporting process with the APS process. The presence of a CPS form and the lack of an APS form also engendered confusion. Development of an APS form, even if it were voluntary rather than mandatory, could alleviate this difficulty.

Confusion among the many agencies required to resolve elder abuse problems was another communication problem. Workers complained that conflicting information was often received in reports about a single case from different reporters, including doctors, nurses, social workers, and APS investigators. Some of these differences may simply be a result of different perspectives; however, better communication could help

resolve these misunderstandings. Communication about the proper handling of a case was also a problem. For example, both APS and health workers complained that courts were not responsive to the needs of elders needing guardians. Even when they felt they had obtained agreements with the courts, agencies often found that the nature of the agreement had not been communicated to lower level personnel responsible for carrying out the court's instructions. Similar lack of an effective response was reported with the police, guardians, or attorneys.

There was considerable agreement among all types of agencies that certain areas of concern were not handled well within the APS mandatory reporting system. One such area is the management of cases involving mentally incompetent adults. As indicated APS is committed to maintaining the independence of competent adults to the greatest degree possible. Other agencies become annoyed at times by APS's lack of action in cases where APS considers the adult capable of making his/her own decisions, some of them bad, and the other agency is anxious to resolve problems this may generate in local communities. More critically, there is often a problem determining whether an individual is indeed competent. APS workers themselves mentioned that they lacked training in this area and were dependent upon physicians and mental health workers to provide input. However, they often had difficulty obtaining useful and timely evaluations in this regard. Furthermore, once a determination of incompetence was made, many agencies, including APS, were most dissatisfied with the manner in which the affairs of mentally incompetent adults were supervised by guardianship agencies and the courts. Clearly, the diagnosis and management of mentally incompetent elders deserves greater attention, both at the policy and the administrative levels.

Conclusions:

All agencies seemed to agree with the recommendations of the Governor's Task Force (2006), which found that certain types of abuse and neglect were woefully neglected, and that remedies were needed to compensate for this lack. The lack of attention to financial abuse of the elderly was widely recognized. Also seen as receiving little attention were cases of neglect and self-neglect. It was also recognized that the agencies which have proven most successful, to date, in identifying elder abuse, the health agencies, are often not in a position to observe these types of abuse. Hospitals and doctors rarely see evidence of financial abuse. Even neglect and self-neglect is not likely to come to their attention unless it is extreme. As the Task Force suggested, the involvement of a wider range of reporters, such as bank officials for financial abuse, is needed. The Task Force also recommended a greater involvement on the part of legal institutions, such as courts and the police, and urged that laws be changed to make it easier to arrest and prosecute persons committing offenses against the elderly. Agency workers interviewed certainly agreed with this recommendation.

There were a number of other areas in which the agency respondents confirmed the recommendations of the Task Force. These recommendations focused on strengthening the present structure for dealing with elder abuse, as well as developing new initiatives to deal with issues not presently being confronted. With regard to the present system, all believed that mandatory reporting would be improved by a higher

degree of professional training, both of mandated reporters and of workers in the APS system. Mandated reporters often lack the most basic information concerning how to make reports and where they should be directed for various types of abuse; APS workers realized they also needed more training, particularly in mental competency issues.

Everyone – the Task Force, APS workers, and agency workers – all recognized that the levels of staff assigned to adult protective service are woefully inadequate. These are very personnel intensive activities, requiring a high degree of skill in identification of symptoms and evaluation of needs and services. The time required to investigate a case, determine client needs, and locate services to resolve the problems is enormous. Adequate management of these cases is well nigh impossible with current staffing levels.

Another critical issue which the Governor's Task Force (2006) mentioned was the need for more coordination among the various agencies responsible for dealing with adult abuse. The Task Force urged the establishment of a "Focal Point," to help develop this coordination. The descriptions of various problems encountered by project respondents made it clear that this greater coordination is a critical need. In numerous instances, workers in both State and private agencies reported problems in obtaining necessary cooperation from other agencies. Even agencies, such as health agencies, which were active in the mandatory reporting to APS, complained of miscommunications and difficulties in their interchanges with APS. Improving communication and coordination could help alleviate these problems and enhance effectiveness of the present system.

Special efforts would be required to establish relationships with agencies not actively working with elder abuse at present. Courts in particular were mentioned as agencies which failed to provide necessary assistance in elder abuse cases. And efforts are needed to extend the mandatory reporting system to agencies not presently involved. Clearly, the senior centers did little reporting to APS. Some were downright hostile. It is likely that special effort to work with these agencies will be necessary.

With regard to new initiatives, both groups stressed the need for greater emphasis on the more frequently observed types of abuse, namely, financial abuse, neglect, and self-neglect. Related to this was the need for involvement on the part of professionals not currently active participating in the effort to halt elder abuse. In particular, both the Task Force and the respondents targeted financial and legal institutions: banks, courts, and the police. Project respondents indicated that improved relationships with courts and the police were particularly critical. Also recommended by the Task Force was legislative action, to review the present laws and determine whether additions and changes were necessary. Workers in all aspects of effort with elder abuse victims were particularly annoyed that they were rarely consulted by State officials regarding efforts to deal with these difficult problems. Finally, there was general agreement that the problems of older adults are presently being neglected, and greater attention in this area is critical.

PROJECT OBJECTIVE: EVALUATION AND DEVELOPMENT OF MODELS:

The major objective of this project has been to evaluate the current model for identifying and providing services to abused elders, to determine whether alterations in the model are necessary, and to recommend alternatives if appropriate. The research was undertaken to learn from agency personnel the current state of services, and determine whether changes were necessary. As a result of the research summarized above, two levels of recommendations are submitted. One level focuses on the current model, the Mandatory Reporting Model, evaluates its effectiveness, and suggests changes which might be needed. The second level discusses the need for new models which might be a useful addition to the present model. (A summary of the problems and recommendations can be found in Table 6.)

Need to Improve the Michigan Mandatory Reporting Model:

As indicated in the introduction to this Report, the model employed by the State of Michigan to reach its objectives to identify and resolve the problem of elder abuse is the Mandatory Reporting Model. This approach requires that specific categories of professionals who work with older adults learn to recognize the symptoms of elder abuse, and report suspicious cases to a State agency.

The research showed that the Mandatory Reporting Model has been successful in encouraging some professionals to make the effort to observe characteristics of elders, to identify elders who exhibit suspicious symptoms, and report their suspicions to the State as required. However, a number of problems were encountered. In order for the State's efforts to alleviate elder abuse to be successful, a number of alterations are clearly necessary. Some of these require changes in the Mandatory Reporting Model. Others may require the adoption of additional models. Below we have listed several problems with the Mandatory Reporting Model, together with suggestions for remedying them:

PROBLEM: Workers in all service agencies perceive that the needs of vulnerable older adults are subordinated to the needs of children by government agencies at all levels.
RECOMMENDATION: The needs of vulnerable adults should receive a higher priority in government services and funding.

PROBLEM: Mandated reporters are unclear on the specific dimensions of mandatory reporting.
RECOMMENDATION: Provide more opportunities for training for mandatory reporters; a standardized format for reporting might also be helpful.

PROBLEM: APS workers are unclear on some issues they confront (such as mental incompetency).
RECOMMENDATION: Provide more training for both APS workers and mandated reporters.

PROBLEM: The number of APS staff available to handle reported cases is very low.
RECOMMENDATION: Increase the number of APS workers, at least to the 1998 level.

PROBLEM: Some abusers of the elderly are repeaters; their past offenses are not known to elder care agencies which hire workers.
RECOMMENDATION: A registry of previous offenders is needed.

PROBLEM: There is a lack of communication and coordination among the various professionals involved in mandated reporting (APS workers, mandated reporters, and agencies whose involvement is needed to remedy the problems).
RECOMMENDATION: Develop a mechanism, such as an elder abuse task force or network of service providers (a "Focal Point"), to bring workers in various fields together to improve communication and coordinate activities on behalf of abused seniors. This network or task force should involve professionals at the highest levels of the various professions, including APS, the courts, law enforcement, guardianship agencies, social service providers, senior centers, and members of the legislature and executive branches. Some counties already have such networks; they should be expanded to all counties, as well as to the State as a whole.

PROBLEM: Workers involved in adult protective service activities, both in private agencies and in APS, often perceive that their views are not heard by officials involved in the development of State policy and procedures.
RECOMMENDATION: Program development at the State level should make great efforts to involve professionals who do the actual work of identifying and reporting abuse of the elderly in order to insure that policy takes account of the reality of the situation.

Need to Consider the Addition of Other Models:

Why is it not sufficient to continue with the Mandatory Reporting Model? Why can we not continue with the same model and encourage additional workers in new areas to participate in the process of identifying and reporting suspected cases of abuse? Or should we try something new? This question was asked of respondents in the focus groups. One State worker responded:

> Not that mandatory reporting is bad – that's not what I'm saying by any means. But when you put all your eggs in that basket and say by, simply having a requirement by some professions or service folks to report, are we making it better for a lot of these folks? Are we really encouraging or are we in fact now putting folks in a position to say well, I know I'm supposed to report but if I do I'm going to be creating a [difficult] situation for this individual? Even though I know APS is going to keep the information confidential. … Is there a different step I need to take? … maybe I should be talking with my Area Agency on Aging to see if there's some kind of care management or some kind of assessment we can get.… And I think that's one of the dangers that we face by saying everybody should just be a mandatory reporter and that will solve our problem (State E).

This worker is focusing on some of the key problems encountered with the current model which cannot simply be corrected by encouraging new reporters. For example, some patients feel deeply threatened by having their cases reported. Some professionals may be uncomfortable with mandatory reporting. Their skills might be

more appropriate to another model. Case management or legal contributions come to mind. Is it not appropriate to have another model available for these instances?

In an earlier study (Sengstock, et al., 1991), it was found that the recommended model of service delivery made little difference in the types of services provided to clients. Most models recommended to workers tend to focus on the *services* provided. However, they tend to ignore other factors, such as client needs and service workers' professional perceptions and judgments, which also play a role in determining the services to be offered. In reality, however, this study found that workers tended to follow their own professional judgments in their approach to the needs of their clients (Sengstock, et al., 1991). If the model imposed, such as a mandatory reporting model, did not conform to their perceptions of appropriate action, they generally ignored the model and provided the services they believed appropriate.

In effect, the senior centers in our study were doing this in their approach to abused elders, providing the services they had available and ignoring the mandate to report, which they found useless. Hence it is suggested that service delivery models are not likely to be useful if they attempt to force professionals to employ approaches more appropriate to the traditions of other occupations. Models are more effective if they build upon the specific skills of the various types of workers involved, and adapt to the kinds of observations and services to which these professionals are accustomed.

The Mandatory Reporting Model was built upon the skills of social work, primarily through its experience with child protective services. The APS model has managed to obtain the cooperation of some health agencies. This has been accomplished largely by encouraging adaptations in the health agencies to fit in with the mandatory reporting model. Most health agencies have added medical social workers to the health care team, rather than altering the practice patterns of physicians and nurses. A major complaint of APS and health workers who regularly used the mandatory reporting model was the lack of cooperation they received from professionals in other areas, primarily the courts, banks and other financial institutions, guardianship agencies, criminal justice agencies, and mental health workers. Workers involved in senior centers, who could be a major resource in aiding abused elders, were a notable absence in their involvement in the current model.

In order to recruit persons in other professions to join in the effort to remedy elder abuse, it is probably more useful to introduce other models more appropriate to their professional skills, rather than attempt to force them into a Mandatory Reporting Model. We suggest that efforts be made to work with professionals in these areas to determine which approaches would be more adapted to their unique professional skills. This process would require considerable cooperation among the professions involved, as was suggested by the Task Force, in an effort to involve workers in legal agencies and the courts.

In order to effect such a change, the input of all relevant professionals would be necessary. This would include the courts, guardianship providers, attorney, law

enforcement agencies, senior centers, social service agencies, mental health workers, the various regulatory and licensing agencies (for health care, nursing homes, senior day care, and the like). As suggested above, a special task force or network of service providers, which some counties have already developed, could be useful in this regard. Such a task force or network could be charged with considering other models. The current model is based primarily on the Adult Protective Services Model, with major elements of the Public Health Model.

Some alternative models might provide effective supplements to the APS Model. For example, professionals in the legal and criminal justice related professions might be more comfortable with the Victim Advocacy Model or the Restorative Justice Model, both of which draw more heavily on legal skills and practices. Similarly, family and social work agencies, as well as senior centers, might find the component of the Family Caregiver Support Model more conducive to the types of services they are able to provide. Existing models do not appear to deal with the approaches generally taken by banks and financial institutions; such agencies should be consulted concerning the models appropriate to their profession. However, the input of the professionals involved in the development of the selected model(s) is critical if their cooperation is to be insured. Imposition of any model from above is unlikely to be successful.

This process would also require the leadership of the relevant state agencies, primarily the Department of Human Services, Adult Protective Services, and Office of Services to the Aging. It would also require the involvement of the State legislature and executive branches, which would have to enact any laws necessary to implement any changes. Input from all levels of all of these agencies would be critical to the success of any modifications. Simply imposing modifications from above would do little good, and would only generate resistance.

PROBLEM: Professionals in fields other than social work and the medical field generally have little involvement in the current process for assisting abused and neglect elders.
RECOMMENDATION: An effort should be made to supplement the APS model with new models with which these other professionals will be more comfortable.

PROBLEM: Models appropriate to the legal and criminal justice agencies do not exist.
RECOMMENDATION: Legal and criminal justice agencies should be consulted to develop models appropriate to these professions. The Victim Advocacy Model and Restorative Justice Model might be useful suggestions to begin this process.

PROBLEM: Senior centers and family service agencies appear to be uncomfortable with the current model of services to abused elders.
RECOMMENDATION: Alternative models for use in these agencies should be explored with them. The Family Caregiver Support Model or community service models might be useful places to begin these discussions.

PROBLEM: Banks and other financial institutions have been relatively uninvolved in the attack against abuse of the elderly. Their absence results in relatively little impact in the important area of financial abuse, as the Task Force pointed out.
RECOMMENDATION: Banks and financial institutions should be consulted to develop identification procedures and remedies for financial abuse which are appropriate for use in the banking industry.

PROBLEM: The resistance of some professionals to the current APS system is, in large part, due to the failure of the current system to take account of the skills and approaches of the various professions.
RECOMMENDATION: Input of professionals in all professions in the development of models appropriate for use in their professional settings is critical to obtaining the cooperation of members of these professions in assisting abused elders.

PROBLEM: The viability and effectiveness of any model with inadequate funding is questionable.
RECOMMENDATION: Legislative and executive branches must insure that adequate funding is available for the conduct of all of these efforts to identify and assist abused elders, and to insure that the rate of elder abuse is reduced.

TABLE 1

CASES REPORTED TO MICHIGAN ADULT PROTECTIVE SERVICES FOR THREE METROPOLITAN DETROIT AREA COUNTIES DURING TWO PERIODS IN 2006 AND 2007

	SUBSTANTIATED		NOT SUBSTANTIATED		
PERIOD REPORTED	SUMMER 2006	WINTER 2007	SUMMER 2006	WINTER 2007	TOTALS
COUNTY:					
MACOMB	14	13	1	2	30 (14.3%)
OAKLAND	28	19	6	7	60 (28.6%)
WAYNE	44	50	9	17	120 (57.1%)
SUB TOTALS	86	82	16	26	210 (100%)

	SUMMER SUBSTANTIATED?		WINTER SUBSTANTIATED?		TOTALS
	YES	NO	YES	NO	
MACOMB	14	1	13	2	30 (14.3%)
OAKLAND	28	6	19	7	60 (28.6%)
WAYNE	44	9	50	17	120 (57.1%)
SUBTOTALS	86 (84.3%)	16 (15.7%)	82 (75.9%)	26 (24.1%)	
SUBTOTALS FOR PERIOD	102		108		210

TOTALS: SUBSTANTIATED VS. UNSUBSTANTIATED – COMBINED REPORTING PERIODS:

SUBSTATIATED	NOT SUBSTANTIATED	TOTAL
168 (80.0%)	42 (20.0%)	210 (100%)

Notes: "Summer, 2006" refers to cases reported during June and July, 2006. "Winter, 2007" refers to cases reported during February and March, 2007.
The relative sizes of the 3 counties are as follows: Tri-County Total: 4,022,267; Macomb: 831,077 (20.7%); Oakland: 1,206,089 (30.0%); Wayne: 1,985,101 (49.4%) (U.S. Census Bureau, 2007 Estimates).
The State of Michigan records abuse and neglect cases by type of abuse reported. This results in separate cases if two or more types of abuse are reported for a single individual. However, for the purposes of this study, a "case" is an individual person at a single point in time; if multiple types were reported, we classify it as "Multiple" abuse.

TABLE 2

SUBSTANTIATED AND NON-SUBSTANTIATED CASES BY REPORTING AGENCY

REPORTING AGENCY	SUBSTANTIATED	NON-SUBSTANTIATED	TOTALS
HEALTH CARE	66 (79.3%)	17 (20.7%)	82 (39.0%)
MENTAL HEALTH	40 (80.0%)	10 (20.0%)	50 (23.8%)
SOCIAL WELFARE	39 (78.0%)	11 (22.0%)	50 (23.8%)
OTHER GOVERNMENT	20 (83.3%)	4 (16.7%)	24 (11.4%)
PHYSICIAN	3	0	3 *
EDUCATOR	1	0	1 *
SELF	0	0	0
TOTALS	168 (80.0%)	42 (20.0%)	210 (100.0%)

*Note: Percentages have not been computed where the total cases in the base category are less than 10.

TABLE 3

TYPE OF ABUSE REPORTED BY WHETHER OR NOT IT WAS SUBSTANTIATED

TYPE OF ABUSE	REPORTED	SUBSTANTIATED	PERCENT SUBSTANTIATED
SELF NEGLECT	58 (27.6%)	51 (30.4%)	87.9%
NEGLECT	56 (26.7%)	42 (25.0%)	75.0%
MULTIPLE	52 (24.8%)	43 (25.6%)	82.7%
PHYSICAL	26 (12.4%)	20 (11.9%)	76.9%
FINANCIAL	11 (5.2%)	9 (5.4%)	81.8%
EMOTIONAL	4 (1.9%)	3 (1.8%)	*
SEXUAL	3 (1.4%)	0 *	*
ENDANGERMENT	0 *	0 *	*
TOTALS	210	168	80.0%

*Note: Percentages have not been computed where the total cases in the base category are less than 10.

TABLE 4

DESCRIPTION OF FOCUS GROUPS AND THEIR PARTICIPANTS

Agency Type	Wave 1 Groups	Wave 1 Individuals	Wave 2 Groups	Wave 2 Individuals	Total Groups	Total Individuals
State Agency	2	7	3	9	5	16
Health Care	3	15	3	15	6	30
Senior Center	1	3	2	4	3	7
Totals	6	25	8	28	14	53

Note: Agencies have been combined into types to protect the confidentiality of both the agencies and the respondents. Most respondents in the two waves were the same. In a few cases, different individuals had to be substituted.

TABLE 5

MICHIGAN ADULT SERVICES STAFFING LEVELS FROM 1998 TO 2008

Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
# of Staff	649	531	541	538	540	368	353	353	328	328	328

PERCENT DECREASE FROM 1998 TO 2006 AND BEYOND: 321/649 = 49.5%

TABLE 6
RECOMMENDED IMPROVEMENT IN MODELS
FOR ELDER ABUSE IDENTIFICATION AND ASSISTANCE

A. IMPROVING THE CURRENT MODEL:

PROBLEM	RECOMMENDATION
Needs of vulnerable adults subordinated to needs of children.	Vulnerable adults should receive enhanced services and funding.
Mandated reporters unclear on the reporting process.	More training opportunities for mandated reporters.
APS workers unclear on some issues they confront (EX: mental incompetency).	More training opportunities for APS workers.
Inadequate APS staff to investigate effectively the number of reports received.	Increase levels of staffing of APS workers.
Many repeat offenders exist.	A registry of repeat offenders is needed.
Lack of communication and coordination among the professionals involved in mandated reporting.	Develop a task force or network of professionals to work together on elder abuse issues, statewide and all counties.
Workers active in adult protective service activities perceive their perspective is not heard by policy makers.	Policy makers in the legislature and executive branches should make efforts to include input for service workers in the development of policy and procedures.

B. CONSIDERATION OF ADDITIONAL MODELS:

PROBLEM	RECOMMENDATION
Professionals other than social workers and the medical field have little involvement in elder abuse identification and assistance.	Supplement the APS Model with other models more appropriate to these other professions.
Legal and criminal justice agencies have little involvement in elder abuse identification and assistance.	Consider the adoption of the Victim Advocacy and Restorative Justice Models to adapt more effectively to these professions.
Senior centers and family service agencies are little involved in elder abuse identification and assistance.	Consider the Family Caregiver Support Model or community service models as alternative models more appropriate to these agencies.
Banks and financial institutions are uninvolved in elder abuse identification and assistance. This is particularly troublesome in attacking financial abuse.	Work with financial agencies to develop approaches more effective to the banking industry.
Some professions resist the current APS system, which does not make use of the skills of each profession.	Involve workers in the professions in the development of models for their own profession.
No model can be effective without adequate funding.	Legislative and executive branches must insure that adequate funding is available for all efforts to assist abused and neglected elders.

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