Diagnostic and Treatment Guidelines on Elder Abuse and Neglect

It is estimated that between 1.5 and 2 million older adults experience abuse or neglect each year in the United States. Elder mistreatment may be physical, psychological, or financial, and it may be perpetrated by family members or by other informal or formal caregivers. Physicians are encouraged to play an active role in assessment, intervention, and prevention.
(Arch Fam Med. 1993;2:371-388)

Although elder abuse and neglect has occurred for centuries, it is the most recent form of family violence to come to the attention of modern societies. Rigorous study of the problem only began in the last decade, and fewer empirical data are available on elder mistreatment than on other forms of family violence such as child abuse. The earliest modern reports of elder abuse and neglect came from the United Kingdom in the 1970s, when dramatic case reports of the phenomenon, called "Granny battering," shocked the medical community and public. By the end of the 1970s, small case-control studies in the United States confirmed that the problem was common in this country as well. In the mid-1970s, the US Senate Special Committee on Aging issued a series of reports on abuse and neglect occurring in nursing homes, and in 1981, the US House of Representatives Select Committee on Aging conducted hearings in which victimized elders gave firsthand testimony of their plight.

Since 1981, congressional and federal agency inquiries have continued to target elder abuse and neglect, especially in institutional care settings, and the media have continued to highlight the problem. In 1986, the Institute of Medicine published recommendations for preventing elder mistreatment in institutions. In 1990, the Secretary of the US Department of Health and Human Services created an Elder Abuse Task Force, which developed an action plan for the identification and prevention of elder mistreatment in homes, communities, and nursing facilities. The plan also proposes strategies for national research and data collection, technical assistance, training, and public education. In 1991, a National Institute on Elder Abuse was established as part of the Administration on Aging's Elder Care Campaign. Adult protective service organizations now exist in every state to serve vulnerable adults, particularly the elderly in cases involving abuse and neglect.

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Other actions have led to increased public and physician awareness of elder abuse and neglect. Since the 1980s, a small group of researchers has been conducting studies to assess the scope and causes of elder mistreatment, and nearly every state has enacted mandatory reporting laws that require physicians and others to report suspected cases. The 1992 standards of the Joint Commission on Accreditation of Healthcare Orga-

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nizations for emergency departments and ambulatory care centers call for improved identification and management of elder abuse, as well as spouse or partner abuse and child abuse.

Physicians are ideally situated to play a significant role in the detection, management, and prevention of elder abuse and neglect. A physician may be the only person outside the family who sees the older adult on a regular basis, and he or she is uniquely qualified to order confirmatory diagnostic procedures such as blood tests or roentgenography, to recommend hospital admission, or to authorize services such as home health care. Opportunities for detection and intervention vary with the discipline and the site at which the abuse or neglect is encountered. Family physicians, general internists, and psychiatrists may have well-established relationships with older adults and their families that allow them to recognize potential abuse or neglect and to intervene before a catastrophic event occurs. In contrast, emergency department physicians routinely witness the effects of elder mistreatment that require immediate action to ensure the patient's safety and prevent further harm. In institutional settings, physician monitoring of patient health is crucial for preventing abuse and neglect and maintaining standards of care.

Since most instances of abuse and neglect are not reported, physicians in all disciplines must be aware of the potential for mistreatment, its signs and symptoms, and the appropriate forms of intervention. Whenever possible, physicians should work with multidisciplinary teams to ensure thorough assessment, intervention, and follow-up of elderly patients.

The purpose of these guidelines is to:

- sensitize clinicians to the fact that elder abuse and neglect occur commonly and that the problem is likely to be encountered in their medical practices;
- present what is known about its epidemiologic characteristics, clinical manifestations, and history;
- describe barriers to proper identification and management of elder mistreatment;
- outline an approach that physicians can use to facilitate recognition of elder abuse and neglect in a variety of clinical settings;
- identify strategies for management and prevention; and
- discuss relevant ethical and medicolegal issues surrounding detection and reporting of the abuse and neglect.

FACTS ABOUT ELDER MISTREATMENT

While the term *elder abuse and neglect* is commonly used to describe acts of commission or omission that result in harm or threatened harm to the health or welfare of an older adult, many authorities prefer to use the term "elder mistreatment." Mistreatment of the elderly person may include physical, psychological, or financial abuse or neglect, and it may be intentional or unintentional. Intentional mistreatment involves a conscious and deliberate attempt to inflict harm or injury, such as verbal abuse or battering; unintentional mistreatment occurs when an action inadvertently results in harm to the elderly person. Unintentional mistreatment is usually due to ignorance, inexperience, or a lack of ability or desire of the caretaker to provide proper care. (Although this document deals with physicians' responses to elder abuse and neglect perpetrated by others, self-neglect among the elderly is also a major concern for professionals caring for elderly patients. Many of the same agencies listed in this document also handle reports of self-neglect.)

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. Studies often focus on reports of selected populations and many cases are unreported. Victims may be embarrassed, intimidated, and overwhelmed by the situation. They may be fearful of reprisals or unaware of the availability of help. In some cases, victims may be unable to report mistreatment or do not realize that they are being mistreated. Finally, health professionals may ignore signs and symptoms of elder mistreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action.

A 1991 report from Congress suggests that between 1.5 and 2 million older adults (persons older than 60 years) are abused annually in the United States. In one community-based cross-sectional survey, 32 of 1000 older adults reported that they had experienced some form of mistreatment at least once since reaching age 65 years. This same population was asked whether they had been mistreated in the last year—yielding an estimated incidence rate of 26 new cases per 1000 persons aged 65 years or older. It is estimated that only one in 14 elder-mistreatment cases is reported to a public agency. With the elderly segment of the population rapidly increasing, clinicians can expect to see a steady increase in the number of cases of elder mistreatment.

There have been attempts to elucidate risk factors for elder mistreatment both for older adults and their caretakers. These factors are based on etiologic theories on the occurrence of elder abuse and neglect. Unfortunately, none of these theories has been substantiated with good clinical data. However, awareness of such factors and the theories underlying them may help physicians understand, anticipate, and prevent situations in which elder mistreatment may occur.[1]

The transgenerational, or family violence, theory asserts that violence is a learned behavior. Individuals who have witnessed or have been victims of family violence may deal with their problems in a like manner. A second theory implicates a psychopathologic problem of the caretaker in some cases of elder

mistreatment. Alcoholism, drug addiction, or severe emotional problems on the part of the caretaker may predispose to abusive behavior. A third theory argues that medical, functional, or cognitive disability of elderly persons increases their dependency and vulnerability and, therefore, their risk for abuse or neglect. Other authorities point out that the caretaker may be dependent, especially economically, on the older patient. This dependency may lead to resentment and, when combined with other factors, may predispose to mistreatment.

Other theories emphasize stress as an important factor in elder mistreatment. Although the caregiving role is inherently stressful, outside situations such as economic pressures, lack of community support, or increasing care needs may heighten tensions and produce frustrations that lead to abusive behavior. While one theory will not explain all or even a majority of cases of elder mistreatment, it is useful for clinicians to view the interaction of these factors as contributing to the overall behavior pattern.

The following factors should be considered when evaluating a potential case of elder mistreatment:

- Elder mistreatment occurs among men and women of all racial, ethnic, and socioeconomic groups.
- The perpetrator of abuse or neglect is often the spouse or an adult child of the older person, but paid or informal caregivers may also be involved.
- Physical, functional, or cognitive problems in caregivers may prevent them from providing proper care.
- Mental illness, alcoholism, or drug abuse in the older person or the caregiver may be associated with abuse and neglect.
- Social isolation and dependence of the elderly person may increase the risk for mistreatment.
- A past history of abusive relationships may predispose the victim to future mistreatment.
- Financial or other family problems may impair the ability to provide adequate care.
- Inadequate housing or unsafe conditions in the home may increase the likelihood of elder mistreatment.
- Victims often have experienced several forms of elder mistreatment at the same time.

Cases of elder abuse and neglect can be identified by an alert clinician, and realistic interventions exist for management and prevention. However, there are barriers to the identification of elder mistreatment. Some of these barriers stem from societal attitudes about aging. Ageist views of society include a belief that functional decline and frailty are inevitable results of aging. In fact, many of the typical problems encountered in old age are readily amenable to treatment. Problems such as incontinence, confusion, impaired mobility, falling, and "failing to thrive" may be due to treatable underlying organic causes.

Researchers also have noted a general reluctance among primary-care physicians to address family violence in all its forms, and elder mistreatment is no exception. Physicians cite the time-consuming nature of the evaluation, as well as their perceived inability to successfully intervene. Proper evaluation of elder abuse and neglect requires a detailed history from the patient, alleged abuser, and other family members, as well as a thorough physical examination. Unfortunately, current reimbursement policies do not favor such cognitively intensive tasks. Whenever possible, a multidisciplinary geriatric team should be used to conduct the evaluation; the issues surrounding elder mistreatment are complex, and the patient often needs more than one professional's knowledge and expertise.

INTERVIEWING

Physicians should incorporate routine questions related to elder abuse and neglect into their daily practice. Even if the elderly person has a cognitive impairment, it is reasonable to ask about abuse or neglect, since diminished cognitive capacity does not necessarily negate the elderly person's ability to describe mistreatment. The Mini–Mental Status Examination can be helpful in evaluating the patient's cognitive status. If the patient has a significant degree of dementia and cannot answer questions about abuse, the physician should seek out an appropriate respondent who is not likely to be a perpetrator. The physician should consider how the interview can be conducted to afford the maximum of privacy, and how it can be structured so that the patient and family members are interviewed separately. *The interview and examination of an elderly patient should always be conducted first, away from the caregiver or suspected abuser.*

Every clinical setting should have a protocol for the detection and assessment of elder mistreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder mistreatment and document it in a way that allows physicians to look at patterns over time. (Several excellent protocols are available; physicians may wish to consult those produced by Mount Sinai Medical Center and Victim Services Agency Elder Abuse Project in New York, NY, Beth Israel Hospital in Boston, Mass, or the Harborview Medical Center in Seattle, Wash.)

The protocol should include basic demographic questions that enable the physician to determine the patient's family composition and socioeconomic status. It should proceed to general questions that give the physician a sense of the overall well-being of the older person and then screen for the various types of abuse or neglect (physical, psychological, and financial). The protocol should target common indicators for each type of mistreatment and should include specific questions for the patient.

Ask the patient direct questions,[2] such as:

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone taken anything that was yours without asking?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?

Any questions answered affirmatively should be followed up to determine how and when the mistreatment occurs, who perpetrates it, and how the patient feels about it and copes with it. Efforts should be made to determine how serious the danger is and what the older adult thinks can be done to prevent the mistreatment from recurring. Clinicians do not have to prove that elder mistreatment has occurred; they need only document a reasonable cause to suspect that it has. "Reasonable cause" reporting can be as simple as stating that the patient seems to have health or personal problems and needs assistance, especially if the clinician suspects forms of abuse or neglect that are difficult to quantify.

Effective diagnosis of elder mistreatment depends on both professional and patient education. All personnel who come in contact with older patients, including nurses, nursing assistants, social workers, emergency health workers, and physical therapists should be familiar with the protocol and should be alert to the various types of mistreatment and possible risk factors. Physicians also should promote patient education on elder mistreatment, including information about the forms of abuse and neglect, the older person's right to be free from mistreatment, and how to access local resources. Most state departments on aging, adult protective services, and area agencies on aging have materials describing legal rights, prevention strategies, and support services, which physicians can provide to patients in their offices and waiting rooms.[3,4]

DIAGNOSIS AND CLINICAL FINDINGS

The physician should ensure that a comprehensive medical examination is conducted and that the results of the examination are documented, including the patient's statements, behavior, and appearance. Symptoms of elder mistreatment may result from physical abuse or neglect, psychological abuse or neglect, financial or material abuse or neglect, or any combination of these. In a broad sense, elder mistreatment encompasses violation of any legal or human rights that are accorded members of society. These rights promote concepts of self-respect and dignity and include the rights to liberty, property, privacy, and free speech.

Physical Mistreatment

Abuse. This involves acts of violence that may result in pain, injury, impairment, or disease. Examples include:

- pushing, striking, slapping, or pinching;
- force-feeding;
- incorrect positioning;
- improper use of physical restraints or medications; and
- sexual coercion or assault (sexual contact or exposure without the older person's consent or when the older person is incapable of giving consent).

The physician has cause to suspect physical abuse when the elderly patient presents with unexplained injuries, when the explanation is not consistent with the medical findings, or when contradictory explanations are given by the patient and the caregiver. Signs of physical abuse include bruises, welts, lacerations, fractures, burns, rope marks (note bilateral injuries and injuries in various stages of healing); laboratory findings indicating medication overdose or undermedication; and unexplained venereal disease or genital infections.

Neglect. This is characterized by a failure of the caregiver to provide the goods or services that are necessary for optimal functioning or to avoid harm. This may include:

- withholding of health maintenance care, including adequate meals or hydration, physical therapy, or hygiene;
- failure to provide physical aids such as eyeglasses, hearing aids, or false teeth; and
- failure to provide safety precautions.

Physical neglect may be suspected in the presence of dehydration, malnutrition, decubitus ulcers, poor personal hygiene, or lack of compliance with medical regimens.

Psychological Mistreatment

Abuse. This is conduct that causes mental anguish in an older person. This includes:

- verbal berating, harassment, or intimidation;
- threats of punishment or deprivation;
- treating the older person like an infant; and
- isolating the older person from family, friends, or activities.

Neglect. This is the failure to provide a dependent elderly individual with social stimulation. This may involve:

- leaving the older person alone for long periods of time;
- ignoring the older person or giving him or her the "silent treatment"; and
- failing to provide companionship, changes in routine, news, or information.

The possibility of psychological abuse or neglect should be investigated

if the older person seems extremely withdrawn, depressed, or agitated; shows signs of infantile behavior; or expresses ambivalent feelings toward caregivers or family members.

Financial or Material Mistreatment

Abuse. This involves misuse of the elderly person's income or resources for the financial or personal gain of a caretaker or advisor, such as:

- denying the older person a home;
- stealing money or possessions; and
- coercing the older person into signing contracts or assigning durable power of attorney to someone, purchasing goods, or making changes in a will.

Neglect. This is failure to use available funds and resources necessary to sustain or restore the health and well-being of the older adult.

Financial abuse or neglect should be considered if the patient is suffering from substandard care in the home despite adequate financial resources, if the patient seems confused about or unaware of his or her financial situation, or has suddenly transferred assets to a family member. Older adults are particularly vulnerable to this type of mistreatment, yet it may be the most difficult to identify.

Violation of Personal Rights

This occurs when caretakers or providers ignore the older person's rights and capability to make decisions for himself or herself. This failure to respect the older person's dignity and autonomy may include:

- denying the older person his or her rights to privacy;
- denying the older person the right to make decisions regarding health care or other personal issues, such as marriage or divorce; and
- forcible eviction and/or placement in a nursing home.

This type of abuse may be recognized through reports by the patient or through observation of family or patient-caregiver interactions.

ASSESSMENT

The physician should consider the following in assessing for elder mistreatment (**Figures 1 and 2**).

Safety

- Is the patient in immediate danger? If so, consider hospital admission and/or a court protective order.
- Does the patient understand risks and consequences of the decision concerning safety? What steps can be taken to increase safety in nonemergency situations?

Access

- Are there barriers limiting or preventing further assessment? If so, the physician may improve access by engaging a trusted family member or friend of the patient, by consulting state adult protective services, and by building a cooperative relationship with local legal advocacy programs.

Cognitive Status

- Does the patient have cognitive impairment on the basis of dementia and/or delirium? Formal, brief instruments such as the Mini–Mental Status Examination can provide an objective, reliable assessment of this.
- If cognitive impairment is present,

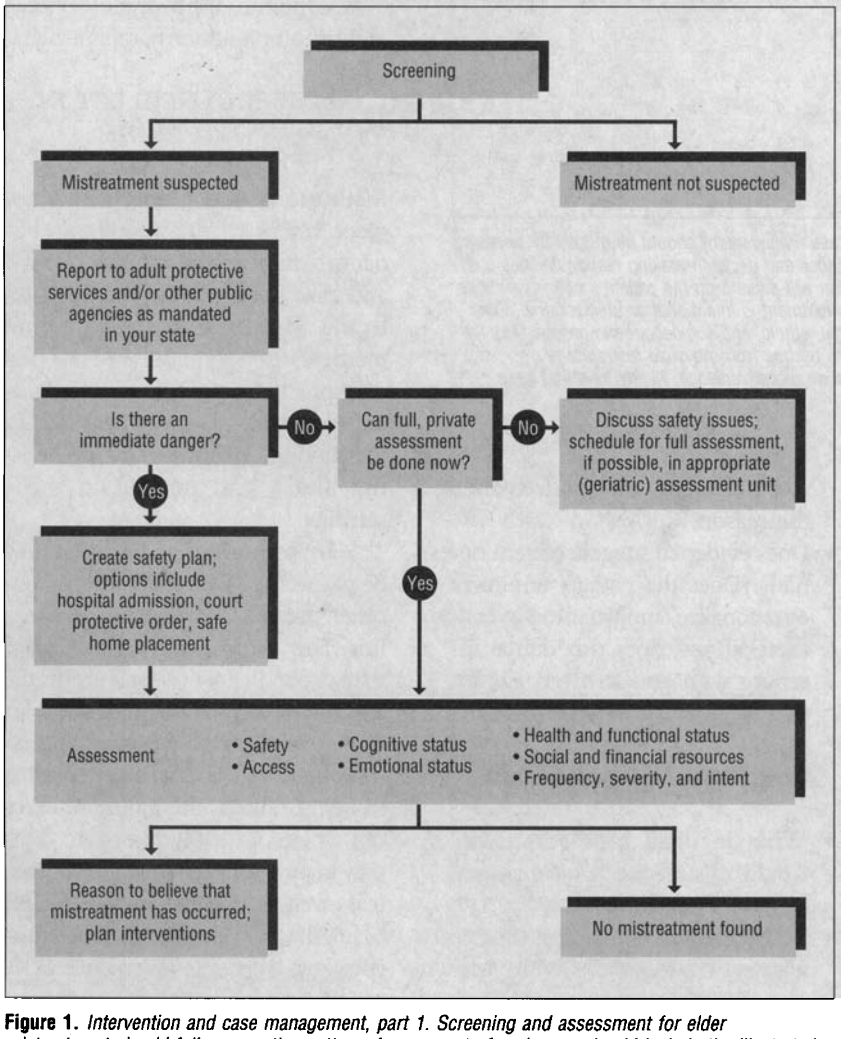

Figure 1. *Intervention and case management, part 1. Screening and assessment for elder mistreatment should follow a routine pattern. Assessment of each case should include the illustrated pattern.*

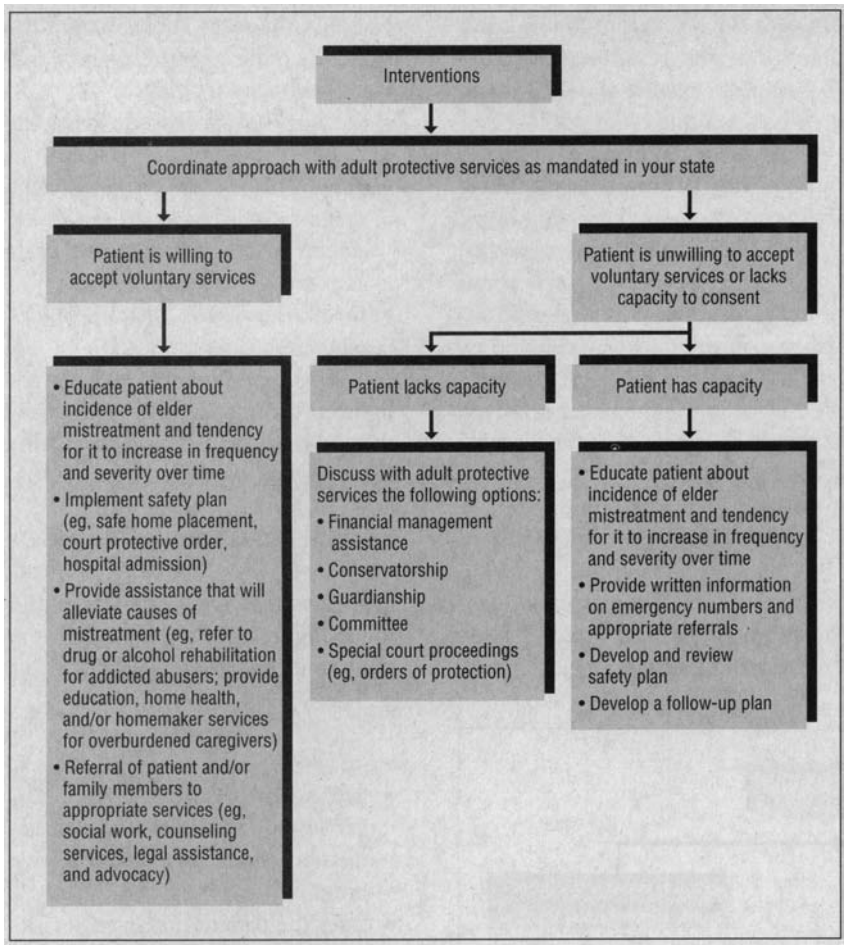

Figure 2. *Intervention and case management, part 2. Case management should be guided by choosing the alternatives that least restrict the patient's independence and decision-making responsibilities and fulfill state-mandated reporting requirements. Intervention will depend on the patient's cognitive status and decision-making capability and on whether the mistreatment is intentional or unintentional. Elder mistreatment occurs among men and women of all racial, ethnic, and socioeconomic groups. Ask the patient direct questions. Residents also have the right to be free from physical restraints or psychoactive drugs administered for purposes of discipline or convenience. Nearly all states have mandatory reporting laws.*

is it potentially reversible or remediable (is it due to medications, thyroid disease, depression, or other organic causes)?
- If irreversible cognitive impairment is present, is it severe enough to preclude an accurate history from the older person? Is it severe enough to impair decision-making capacity?

Emotional Status

- Does the patient manifest depression, shame, guilt, anxiety, fear, and/or anger? If yes, explore beliefs associated with these emotions.
- Is the patient reluctant to discuss the possibility of abuse or neglect? If so, attempt to determine the reason.
- Does evidence suggest patient denial? (Does the patient minimize or rationalize family tension or conflict?) If yes, does this denial interfere with patient's recognition or admission of mistreatment?

Health and Functional Status

- What medical problems exist? Could mistreatment have caused or exacerbated them?
- If the patient requires assistance with activities of daily living, who provides it? Does the person have the emotional, financial, and intellectual ability to provide the care?

Does the patient have physical limitations that impair his or her ability to protect himself or herself?

Social and Financial Resources

- Does the patient have family or friends able and willing to nurture, listen, and assist with care, if needed? If not, why not?
- Does the patient have adequate financial resources for basic substantive needs? If yes, but these needs are not being met, why is this?

Frequency, Severity, and Intent

- Has mistreatment increased in frequency or severity over time?
- Are there motives or remediable causes for the mistreatment? If so, incorporate appropriate services into intervention/treatment plan.

ABUSE AND NEGLECT IN INSTITUTIONS

Institutional elder abuse and neglect refers to mistreatment that occurs in nursing homes, board and care homes, and other assisted living facilities. Nursing home medical directors, as well as private practitioners who see individual residents, play a critical role in identifying, treating, and preventing abuse and neglect in these settings.

In institutions, elder abuse may be perpetrated by a staff member, another patient, an intruder, or a visitor. The forms of abuse and neglect that occur in institutions are virtually the same as those that occur in domestic settings. One form of mistreatment that is of special concern in institutions is the failure to carry out a plan of treatment or care. This may involve unauthorized use of physical or chemical restraints or the use of medication or isolation as punishment, for staff convenience or as a substitute for treatment and in conflict with a physician's order. Physicians must be aware that substan-

dard care or routine neglect can result in declining health, serious deterioration, pain, and emotional trauma. The plan of care is a critical document used to determine whether action or inaction by facility staff is abusive or neglectful.

Older persons in institutional care are at risk for mistreatment both because of their extreme vulnerability and because of inadequate training and experience among caregivers. Residents of nursing facilities are typically dependent, extremely frail, and/or chronically ill, and many do not have regular visitors who can monitor their care. Cognitive, vision, and hearing impairments are common; a recent government report states that at least one half of all nursing home residents—about 600 000 individuals—suffer from dementia. Patients with cognitive impairment may be resistant to care, and difficult to help. In addition, problems such as insufficient resources, staff shortages, high turnover, and inadequate supervision and training increase the risk of mistreatment. Finally, abuse and neglect may be exacerbated by societal ignorance about quality care and by the acceptance of abusive or neglectful behavior as inevitable in institutional life.

Although institutional abuse and neglect has been recognized for more than 40 years, there are no uniform national prevalence data. Sources of information include state licensure and certification agencies, state Medicaid and Medicare fraud and abuse agencies, long-term–care ombudsman programs established under the Older Americans Act, and most state adult protective services programs. Data collection should be improved through planned improvements in the federal Medicare and Medicaid facility survey system, new reporting requirements to state nurse aide registries, and revised ombudsman and adult protective service program reporting requirements.

Regulations and Legal Protection

All but a small number of private nursing facilities are monitored by state and federal regulatory agencies, and other specialized programs, with expectations that public standards of care will be provided. Even so, there is continual concern and increasing information about serious mistreatment in government-licensed and certified facilities. Nonmedical residential facilities or board and care homes usually do not employ health and medical staff. Although most states license such facilities, they do not provide active regulation of the standards of care. Information about abuse and neglect in board and care homes is often obtained by physicians (particularly emergency department staff), family members, investigators, and, increasingly, by the state long-term–care ombudsman program.

Most states have legislation that addresses elder mistreatment; such statutes are usually contained in adult protective service or domestic violence legislation. Several states (including Delaware, Georgia, Maryland, Massachusetts, Missouri, and Oregon) have laws specific to the institutional setting. Many state laws identify physicians and other health-care providers as key professionals who must report suspected abuse and neglect to state officials.

National standards for care in nursing homes are based on public policy set forth in the Nursing Home Reform Act of 1987 (Public Law 100-203; Social Security Act, Title C). This law, as part of the Omnibus Budget Reconciliation Act, is often referred to as "OBRA '87." (It became effective October 1990.) The intent of the law and its regulations is to promote high-quality care and to prevent substandard care, abuse, and neglect.

The law provides that a set of residents' rights are ensured for each person. These include protection against Medicaid discrimination; the right to participate in health-care decisions and to give or withhold informed consent for particular interventions; safeguards to reduce inappropriate use of physical and chemical restraints; provisions to ensure proper transfers or discharges; and full access to a personal physician, the long-term–care ombudsman, and other advocates. Each resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. According to the federal guidelines for implementation of the law, "abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being."[5]

Residents also have the right to be free from physical restraints or psychoactive drugs administered for purposes of discipline or convenience. The inappropriate use of physical or chemical restraints is of special concern. Federal guidelines specify that "the decision to apply physical restraints should be based on the assessment of each resident's capabilities, an evaluation of less restrictive alternatives, and the ruling out of their use. The plan of care should also contain a schedule or plan of rehabilitative training to enable the progressive removal of restraints or the progressive use of less restrictive means, as appropriate."[5]

Despite federal and state laws to protect residents, abuse and neglect continue to occur for a variety of reasons. Some states have lax enforcement of standards. Many residents do not have regular visits from family and friends who can monitor their care; and not all communities have local long-term–care ombudsman programs to help residents resolve problems and complaints.

The Role of the Physician

Both because of their prescribed roles and because they may be among the

few persons from outside the facility to see the resident on a regular basis, physicians can play a critical role in identifying, treating, and preventing abuse and neglect in institutional settings. State laws require that patients be admitted by physicians to nursing homes (and, in some cases, to other types of residential facilities). After admission, each resident's care must be under the supervision of an attending physician (or a physician assistant, nurse practitioner, or clinical nurse specialist supervised by a physician), and facilities are mandated to provide them immediate access to their patients. Several of the prescribed roles for personal physicians are likely to permit recognition and prevention of institutional abuse and neglect. These include:

- participating in the development and monitoring of the resident's plan of care;
- assessing the need for and prescribing physical restraints and antipsychotic drugs only when appropriate for treatment of a resident's particular condition and not for behavioral modification or control; and
- monitoring reports that by law must go to the physician, including any irregularities in drug regimen as found by the pharmacist who conducts a monthly drug regimen review of all residents, and findings of substandard care by the state's inspection agency.

New legal requirements under the Omnibus Budget Reconciliation Act should help to reduce the inappropriate use of physical and chemical restraints. Physicians should be aware that these regulations will cause their medical prescriptive decisions to be more closely reviewed to ensure that psychotropic drugs are prescribed appropriately, ie, for diagnoses of dementia. Personal physicians can play a crucial role in the identification and prevention of mistreatment by ongoing monitoring of the resident's health through regular physical examinations, review of the patient's record, and review of resident assessments. These assessments must be completed annually, with updates every quarter and whenever there is a significant change in the patient's condition. Other physicians may identify and prevent institutional elder mistreatment while serving as medical directors or as physician members of the facility's quality assessment and assurance committee. A physician may serve in all three of these capacities at the same time.

DOCUMENTATION

Thorough, well-documented medical records are essential. They provide concrete evidence and may prove to be crucial to the outcome of any legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Records should be kept in a precise, professional manner and should include the following:

- chief complaint and description of the abusive event or neglectful situation, using the patient's own words whenever possible rather than the physician's assessment;
- complete medical history;
- relevant social history;
- a detailed description of injuries, including type, number, size, location, stages of healing, color, resolution, possible causes, and explanations given (where applicable, the location and nature of the injuries should be recorded on a body chart or drawing);
- an opinion on whether the injuries were adequately explained;
- results of all pertinent laboratory and other diagnostic procedures;
- color photographs and imaging studies, if applicable; and
- if the police are called, the name of the investigating officer and any actions taken.

In addition to complete written records, photographs are particularly valuable as evidence. The physician should ask the patient for permission to take photographs. When the patient is unable to give consent, photographs may be taken and a surrogate decision-maker may need to be consulted after the fact. Imaging studies also may be useful. State laws that apply to the taking of photographs usually apply to roentgenograms as well.

- When possible, take photographs before medical treatment is given.
- Use color film, along with a color standard.
- Photograph from different angles—full body and close-up.
- Hold up a coin, ruler, or other object to illustrate the size of an injury.
- Include the patient's face in at least one picture.
- Take at least two pictures of every major trauma area.
- Mark photographs precisely and promptly with the patient's name, location of injury, date, time of day, and names of the photographer and others present.

For medical records to be admissible in court, the physician should be prepared to testify:

- that the records were made during the "regular course of business" at the time of the examination or interview;
- that the records were made in accordance with routinely followed procedures; and
- that the records have been properly stored and their access limited to professional staff.

LEGAL CONSIDERATIONS

The first priority of the physician when mistreatment is detected or suspected is to ensure the safety of the victim. The second is to report the case to the appropriate state agency, such as adult protective services, in accordance with state laws that govern elder abuse and neglect. The physician's legal obligations may vary depending on whether the patient resides at home or in an institution. In cases of abuse or neglect in the home, the physician simultaneously may request a variety of other services, including respite

care, a visiting nurse service, and a social work evaluation. Awareness of some general principles in the initial stages, such as not confronting the perpetrator and not blaming the victim, is likely to result in a better outcome. The patient's safety and well-being is the goal of any intervention, and must be the physician's primary concern.

A competent older adult who is not being coerced may choose to stay in an abusive situation. In such cases, the physician's role in assessment and referral may be more complicated than it would be in the case of an incompetent patient. On the other hand, most patients and their families welcome physician support and referrals for home services and respite care. This is particularly true when mistreatment results from the caregiver being overburdened and there is no malicious intent. It is usually less intrusive and threatening to the family to have these interventions suggested by a physician or other professional who is known to them than by an unfamiliar physician or caseworker.

The primary-care physician can participate in ongoing treatment or at least serve as a monitor who can reactivate assistance if the situation is deteriorating and provide follow-up after a referral has been made. If an abused elderly person is treated by a physician who does not inquire about or make an assessment for elder mistreatment, that physician may be held liable for any subsequent injuries. In some states, failure to report is a misdemeanor, the penalty for which may be a fine or even imprisonment.

Elder mistreatment is a complex problem that requires the assistance of a variety of individuals including social workers, visiting nurses, in-home health aides, and, occasionally, legal and financial experts. Geriatric assessment programs at large hospitals are ideally equipped to respond in these situations. The alternative is for informal community-based teams to respond on an ad hoc basis. A multidisciplinary approach benefits the victim of mistreatment and also lessens the burden of responsibility shared by the professionals involved in the case.

Reporting Requirements and Ethical Dilemmas

Nearly all states have mandatory reporting laws that require a variety of designated health-care professionals and paraprofessionals to report suspected elder abuse and neglect to a designated state authority, usually the adult protective service agency, department of aging, or ombudsman. Some state laws specify that once authorities have been alerted to even the suspicion of elder abuse or neglect, an agent of the state will make an on-site investigation in an attempt to corroborate the report.

There is considerable debate as to whether mandatory reporting laws aid in the identification of elder abuse and neglect. A recent study by the US General Accounting Office concluded that states with mandatory and nonmandatory reporting laws could not be meaningfully compared because of differences among the states in investigative mechanisms, definitions of abuse and neglect, and who is defined as a mandatory reporter. There also is no consensus among states on the definition of the elderly population by age. An accompanying survey of protective service officials concludes that raising public and professional awareness of the problem of elder abuse and neglect is much more important in uncovering cases than any legislative edict.

While at first glance mandatory reporting laws seem to be an admirable attempt at identifying more cases of elder abuse and neglect, some observers have criticized their advent as an ageist response to the problem. They argue that older adults who are victims of family violence should have the same opportunity as younger adults to endorse or refuse referral to an investigating agency. Mandatory reporting laws for elder abuse and neglect, like child abuse statutes, are based on the state's *parens patriae* power to protect persons who cannot or will not protect themselves.

Thus, mandatory reporting laws can engender difficult ethical dilemmas for the physician. He or she has taken an oath to maintain the confidentiality of the physician-patient relationship, but may have to violate that trust to comply with certain state laws. How then should the physician proceed in cases in which clear historical or physical evidence of abuse or neglect is present but a competent patient requests that no report be made? The physician should explain to the patient that he or she is obligated to report suspected mistreatment and should strive to maintain a positive physician-patient relationship, keeping in mind the medical need for intervention. The goal is not to punish the individual or family, but to stop the abuse or neglect and to access help in the form of outside resources. While there is little case law on this subject, most experts would agree that a physician's legal duty to report cases of suspected abuse would supersede the issue of physician-patient confidentiality.

Another useful strategy is to maintain a good working relationship with local adult protective service personnel. In addition to investigating abuse, these professionals are typically charged with serving as advocates for frail elderly in the community. They often procure a variety of services to which the older person is entitled that may not be related to elder abuse or neglect. Accordingly, a home visit by one of these professionals can be used to gain information about the health and safety of the patient.

Most adults in need of help allow adult protective services to work with them. However, capable adults have the legal right to refuse the provision of ongoing protective services. For the incapacitated older per-

son who insists on remaining in an abusive environment, the court may need to appoint an impartial conservator who can manage his or her finances and affairs, and/or a guardian who is responsible for health care and other decisions. In such cases, the physician's role includes the documentation of cognitive and other findings to determine a patient's capacity, which may aid the court in a competency hearing.

Testimony

Some physicians are concerned about the time and inconvenience involved with a court appearance. In some cases, medical records can be admitted without requiring the physician's in-court testimony. However, if testimony is required, it may be possible to place the physician "on call" so that she or he need appear only when it is time to testify.

The physician may testify about general observations of behavior or statements made, a function that is distinct from the use of the physician as an expert. A physician should never feel insulted if called to give only this type of "layperson" testimony or to testify about a nonmedical issue, because this may be the only way to get such information before the court. When called as an expert witness, the physician may be requested to give an opinion on whether the explanation given is consistent with the injury.

For any testimony, the following guidelines should be followed:

- Insist on pretrial preparation by the attorney presenting you as a witness.
- Determine the legal and factual issues and how your testimony relates to these issues.
- Determine what demonstrative evidence (ie, photographs) should be part of your testimony.
- If testifying as an expert witness, propose questions for the attorney to ask.
- Brief the attorney on questions to ask the opposing expert.
- Answer only the questions asked.
- If a question is not understood, ask that it be repeated; explain when a one-word answer is not enough.
- Do not volunteer information.
- Calmly correct an attorney who misstates prior testimony.

RISK MANAGEMENT

Duty to the Victim

Most physicians will encounter cases of elder abuse and neglect in their practices. Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and/or report cases of suspected mistreatment. In general, doing what is medically best or most appropriate is good risk management. The duty to the victim may arise from the special relationship between physician and patient or from the courts' interpretations of reporting laws. The argument would be that other physicians, under the same circumstances, would have diagnosed inflicted trauma and taken appropriate management steps that would have prevented subsequent harm.

Thus, physicians must be willing to ask all elderly patients about mistreatment and should know how to diagnose it. *Failure to conduct the interview and examination apart from the suspected perpetrator may interfere with an accurate diagnosis.* Physicians must be prepared to intervene in situations that are particularly dangerous for the elderly person such as repeated, similar injuries; malnutrition or dehydration; undermedication or overmedication; mental illness in the patient or caregiver; substance abuse by the patient or caregiver; and threatened suicide by the caregiver (there may be increased risk for a murder/suicide).

In states that have enacted mandatory reporting statutes, a physician's failure to report could give rise to liability, but since reporting laws rarely explicitly give victims such a right to sue, courts must determine whether their state's statutes implicitly contain that right. Physicians could be liable, however, under various common law tort actions, including negligence or wrongful death.

Most states provide that reports of suspected mistreatment are kept strictly confidential. Reporters' names may not be released without written consent. In addition, the physician is immune from any civil or criminal liability for making a good-faith report of suspected abuse or neglect. To be held liable for reporting, the physician would have to be shown to be acting in a knowingly and intentionally false and malicious manner. Reports made in the context of employment are also generally protected against employer retaliation by "whistleblower" and other public welfare statutes.

Reporters should not be reluctant to report incidents or concerns because they seem "minor" or "not threatening"; physicians should report any reasonable suspicion of abuse or neglect. State reporting agencies will prioritize cases and can provide needed interventions such as emergency food and care, transportation, medical evaluation, relocation, legal assistance, and other community-based services.

Duty to Warn

Many states recognize a legal duty that physicians have toward third parties who might be harmed by their patients. In those states, if a physician is aware of a patient's intent to harm a third party, such as the patient's spouse or parent, he or she may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger. Physicians, and especially therapists, should know the law of the area in which they practice.

Despite taking all possible measures to handle cases correctly, physicians may still become defendants in medical malpractice suits. These physicians should:

- not panic;
- not discuss the case with any-

one until they have spoken with their attorney;

- contact their malpractice insurance carriers;
- record the circumstances involved in the serving of a summons; and
- have thorough documentation.

TRENDS IN TREATMENT AND PREVENTION

State programs such as adult protective services and long-term–care ombudsman programs have made it easier for physicians to intervene on behalf of patients who have been victims of elder mistreatment. Depending on the state, adult protective statutes may include a statewide system with the capability of immediate investigation and emergency services, including evaluation, counseling, and, if needed, relocation. Physicians may contribute to the success of state services by serving as trainers for adult protective services, explaining how mistreatment is diagnosed, and offering suggestions for improving the effectiveness of interventions. They may also wish to serve on advisory committees in their state or county medical societies. As more research is conducted on elder abuse and neglect, more information will be available to assess protocols and medical and legal interventions.

One of the most important developments in addressing elder mistreatment in recent years has been the use of multidisciplinary teams in hospitals and communities. Specialists in geriatrics, social work, nursing, psychiatry, and other fields offer insight that can help the primary-care physician to develop an appropriate intervention plan. These specialists may have important referral information for patients or family members—support groups and other services in the community that focus on aging parents, home care, substance abuse, family violence, and financial and legal planning. Perhaps most important, physicians need to become familiar with long-term care and in-home health-service options in their communities. Caring for an elderly parent at home is inherently stressful, and abusive situations can be prevented by providing support to overburdened caregivers.

RESOURCES FOR PHYSICIANS

The following resources are available to assist physicians in their evaluation and interventions on behalf of elderly patients. Physicians should become familiar with their own state resources and state laws that deal with elder abuse and neglect.

State Elder Abuse Hot Line

Most states have instituted a 24-hour toll-free number for receiving reports of abuse and neglect. Calls are confidential.

Adult Protective Services

This is the primary service agency with legal responsibility and authority to investigate reports of abuse and neglect in the home and community and in institutions (in a majority of states) and to provide services to elderly victims. Adult protective services works closely with the medical community to obtain services that will increase the older person's safety and well-being.

Law Enforcement

Local police and sheriffs are being given more power to intervene in cases of family violence, and they may have already been notified of the abuse or neglect by the elderly person or by a friend or advocate. Where state statutes define elder mistreatment as a crime, physicians may be required to report suspected abuse to a law enforcement agency. Some forms of abuse are crimes that must be prosecuted; these may include cases involving sexual abuse or assault.

Long-term–Care Ombudsman Program

Every state has a long-term–care ombudsman program, as established by the Older Americans Act in 1978. Each program provides regular visitation of nursing facilities by an ombudsman and trained volunteers; these services may be extended to board and care facilities. Information about the ombudsman program is provided through local area agencies on aging, and such information is required to be posted in nursing facilities.

Facility Abuse Investigations

Every nursing-care facility must have a process for investigating reports of abuse, neglect, and misappropriation of resident property.

State Licensure and Survey Agency

The state agency responsible for survey and certification of nursing facilities has developed a process for the receipt, timely review, and investigation of allegations of abuse and neglect and misappropriation of resident property by staff or other providers of services to patients at the facility.

Medicaid Fraud Control Units

Each unit, located in the state attorney general's office, is required by federal law to investigate and prosecute Medicaid provider fraud and patient abuse or neglect in health-care facilities that participate in Medicaid.

Nurse Aide Registry

A registry maintained by the state lists the names of nurse aides who have been found guilty of mistreatment. Nursing facilities are required to check with the registry before hiring staff.

State Boards for Nursing and Medicine

The state must also notify the appropriate licensure authority about abuse and neglect by other health-care professionals.

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of October 1992.

These guidelines were also reviewed by experts in law and geriatric health whose assistance is greatly appreciated. American Medical Association staff assistance was provided by Roger L. Brown, PhD; Sona Kalousdian, MD, MPH; Carol O'Brien, JD; Marshall D. Rosman, PhD; Elaine Tejcek; and Martha Witwer, MPH.

Reprint requests to Department of Mental Health, American Medical Association, 515 N State St, Chicago, IL 60610 (Roger L. Brown, PhD).

STATE UNITS ON AGING AND ADULT PROTECTIVE SERVICE AGENCIES

The organization and structure of adult protective service programs vary among the states. Use the numbers in bold to report suspected cases of abuse or neglect.

Alabama

Elder Abuse Hot Line: In state: **(800) 458-7214**; Oscar D. Tucker, Director, Commission on Aging, Suite 470, 770 Washington Ave, Montgomery, AL 36130; (205) 242-5743.

Gethryn Giles, Director, Adult Services Division, Department of Human Resources, S. Gordon Persons Bldg, 50 Ripley St, Montgomery, AL 36130; **(205) 242-1350**.

Alaska

Connie Sipe, Director, Older Alaskans Commission, Department of Administration, Pouch C-Mail Station 0209, Juneau, AK 99811-0209; (907) 465-3250.

Patricia O'Brien, Coordinator, Adult Protective Services, Division of Family and Youth Services, Department of Health and Social Services, Pouch H-05, Juneau, AK 99811-0630; **(907) 465-2145.**

Arizona

Richard Littler, Director, Aging and Adult Administration, Department of Economic Security, 1400 W Washington St, Phoenix, AZ 85007; (602) 542-4446.

Joseph Zink, Operations Manager, Adult Protective Services, Aging and Adult Administration, Department of Economic Security, 1400 W Washington St, Phoenix, AZ 85007; **(602) 542-4446**.

Arkansas

Elder Abuse Hot Line: In state: **(800) 482-8049** or **(800) 922-5330**; Herb Sanderson, Director, Division of Aging and Adult Services, Department of Human Services, PO Box 1437, Slot 1412, Seventh and Main streets, Little Rock, AR 72201; **(501) 682-2441.**

California

Robert Martinez, Director, Department of Aging, 1600 K St, Sacramento, CA 95814; (916) 322-5290.

Bob Barton, Chief, Adult Services Bureau, Department of Social Services, Adult and Family Services, 744 P St, M 59-536, Sacramento, CA 95813; **(916) 657-2186.**

Colorado

Rita Barreras, Manager, Aging and Adult Services, Department of Social Services, 1575 Sherman St, 4th Floor, Denver, CO 80203-1714; (303) 866-3851.

Joanne Marlatt, Program Administrator for Adult Protection/ Assisted Living, Aging and Adult Services, Department of Social Services, 1575 Sherman St, 4th Floor, Denver, CO 80203-1714; **(303) 866-5910.**

Connecticut

Edith Prague, Commissioner, Department on Aging, 175 Main St, Hartford, CT 06106; (203) 566-3238.

Leslie Burkhart, Program Supervisor, Department of Human Resources, 1049 Asylum Ave, Hartford, CT 06106-2431; **(203) 566-3117.**

Delaware

Eleanor Cain, Director, Division on Aging, Department of Health and Social Services, 1901 N DuPont Hwy, New Castle, DE 19720; (302) 577-4791.

Barbara Webb, Administrator, Division on Aging, Adult Protective Services, Department of Health and Social Services, CT Bldg, 1901 N DuPont Hwy, New Castle, DE 19720; **(302) 421-6791**.

District of Columbia

Jearline Williams, Director, Office on Aging, 1424 K St NW, 2nd Floor, Washington, DC 20005; (202) 724-5626.

Donald Butler, Acting Chief of Social Service, Family Services Administration, Department of Human Services, Randall Bldg, First and I streets SW, Washington, DC 20024; **(202) 727-0113.**

Florida

Elder Abuse Hot Line: In state: **(800) 96-ABUSE;** Bentley Lipscomb, Secretary, Department of Elder Affairs, Bldg 1, Room 317, 1317 Winewood Blvd, Tallahassee, FL 32301; (904) 922-5297.

Christopher C. Shoemaker, Program Administrator, Aging and Adult Services, Department of Health and Rehabilitative Services, Bldg 2, Room 328, 1317 Winewood Blvd, Tallahassee, FL 32399-0700; **(904) 488-2650.**

Georgia

Judy Hagenbak, Director, Office of Aging, 878 Peachtree St, No. 632, Atlanta, GA 30309; (404) 894-5333.

Sara Brownlee, Unit Chief for Adult Services, Division of Family and Children Services, Social Services Section, Department of Human Resources, 878 Peachtree St NE, Suite 503, Atlanta, GA 30309; **(404) 894-4440.**

Hawaii

Jeanette Takamura, Director, Executive Office on Aging, Office of the Governor, 335 Merchant St, No. 241, Honolulu, HI 96813; (808) 586-0100.

Patricia Snyder, Program Administrator; Adult Services, Department of Human Services, PO Box 339, Honolulu, HI 96809; **(808) 548-5902.**

Idaho

Ken Wilkes, Director, Office on Aging, Statehouse, Room 108, Boise, ID 83720; (208) 334-3833.

David DeAngelis, Chief, Bureau of Adult Services, Department of Health and Welfare, 450 W State St, 10th Floor, Boise, ID 83720; **(208) 334-5531.**

Illinois

Elder Abuse Hot Line: In state: **(800) 252-8966;** Maralee Lindley, Director, Department on Aging, 421 E Capitol Ave, Springfield, IL 62701; **(217) 785-2870.**

Indiana

Adult Abuse Hot Line: In state: **(800) 992-6978;** Geneva Shedd, Director, Bureau of Aging/In-Home Services, 402 W Washington St, Room E-431, Indianapolis, IN 46207-7083; (317) 232-7020.

Arlene Franklin, Director; Advocacy Services, Department of Human Services, PO Box 7083, Indianapolis, IN 46207-7083; **(317) 232-1750.**

Iowa

Elder Abuse Hot Line: In state: **(800) 362-2178;** Betty Grandquist, Director, Department of Elder Affairs, Jewett Bldg, Suite 236, 914 Grand Ave, Des Moines, IA 50319; (515) 281-5187.

Sandy Koll, Program Manager, Adult Services, Bureau of Adult, Children, and Family Services, Department of Human Services, Hoover Building, 5th Floor, Des Moines, IA 50319; **(515) 281-6219.**

Kansas

Elder Abuse Hot Line: In state: **(800) 432-3535;** Joanne Hurst, Secretary, Department on Aging, Docking State Office Bldg, 122-S, 915 SW Harrison, Topeka, KS 66612-1500; (913) 296-4986.

Rosilyn James-Martin, Adult Abuse Program, Commission on Adult Services, Department of Social and Rehabilitative Services, Smith-Wilson Bldg, 300 SW Oakley, Topeka, KS 66606; **(913) 296-2575.**

Kentucky

Sue Tuttle, Director, Division of Aging Services, Cabinet for Human Resources, CHR Bldg, 6th Floor W, 275 E Main St, Frankfort, KY 40621; (502) 564-6930.

Richard Newman, Branch Manager, Adult Services, Division of Family Services, Department of Social Services, Cabinet for Human Resources, 275 E Main St, Frankfort, KY 40621; **(502) 564-7043.**

Louisiana

Robert Fontenot, Director, Office of Elderly Affairs, 4550 North Blvd, 2nd Floor, PO Box 80374, Baton Rouge, LA 70806; (504) 925-1700.

Terry Gibson, Administrator, Program Operations Services, Division of Children, Youth, and Family Services, Department of Social Services, 1967 North St, PO Box 3318, Baton Rouge, LA 70820; **(504) 342-9931.**

Maine

Elder Abuse Hot Line: In state: **(800) 452-1999;** Christine Gianopoulos, Director, Bureau of Elder and Adult Services, Department of Human Services, State House Station, No. 11, Augusta, ME 04333; **(207) 624-5335.**

Maryland

Rosalie Abrams, Director, Office on Aging, State Office Bldg, 301 W Preston St, Room 1004, Baltimore, MD 21201; (410) 225-1100.

Handy Brandenburg, Program Manager, Adult Protective Services, Department of Human Resources, 311 W Saratoga St, 5th Floor, Baltimore, MD 21201; **(410) 333-0161.**

Massachusetts

Elder Abuse Hot Line: In state: **(800) 922-2275;** Franklin Ollivierre, Secretary, Executive Office of Elder Affairs, 1 Ashburton Pl, 5th Floor, Boston, MA 02108; (617) 727-7750.

Donna Reulbach, Director, Protective Services, Executive Office of Elder Affairs, 1 Ashburton Pl, 5th Floor, Boston, MA 02108; **(617) 727-7750 Ext 302.**

Michigan

Nancy Crandall, Director, Office of Services to the Aging, PO Box 30026, Lansing, MI 48909; (517) 373-8230.

Ralph Young, Director, Office of Adult and Employment Services, Department of Social Services, 235 S Grand Ave, No. 504, PO Box 30037, Lansing, MI 48909; **(517) 373-2869.**

Minnesota

Elder Abuse Hot Line: In state: **(800) 652-9747;** Gerald Bloedow, Director, Board on Aging, 444 Lafayette Rd, St Paul, MN 55155-3843; (612) 296-2770.

Jim Varpness, Adult Protection Consultant, Aging and Adult Services, 444 Lafayette Rd, St Paul, MN 55155-3843; **(612) 296-4019.**

Mississippi

Elder Abuse Hot Line: In state: **(800) 354-6347;** James Johnson, Director, Council on Aging, Division of Aging and Adult Services, 421 W Pascagoula St, Jackson, MS 39203-3524; (601) 949-2070.

Marva Hayes, Manager, Adult Protection Services, Department of Human Services, PO Box 352, Jackson, MS 39205; **(601) 354-6631.**

Missouri

Elder Abuse Hot Line: In state: **(800) 392-0210;** Bryan Forbis, Director, Division on Aging, Department of Social Services, 615 Howerton Ct, PO Box 1337, Jefferson City, MO 65102-1337; **(314) 751-3082.**

Montana

Charles Rehbein, Acting Aging Coordinator, Governor's Office on Aging, State Capitol Bldg, Capitol Station, Room 219, Helena, MT 59620; (406) 444-3111.

Donald Sekora, Program Officer, Adult Protective Services, Program Bureau, Program and Planning Division, Department of Family Services, PO Box 8005, Helena, MT 59604; **(406) 444-5900.**

Nebraska

Elder Abuse Hot Line: In state: **(800) 652-1999;** Jacklyn Smith, Director, Department on Aging, PO Box 95044, 301 Centennial Mall S, Lincoln, NE 68509; (402) 471-2306.

Mary J. Iwan, Administrator, Special Services for Children and Adults, Medical Services Division, Department of Social Services, PO Box 95026, 301 Centennial Mall S, 5th Floor, Lincoln, NE 68509-5026; **(402) 471-9345.**

Nevada

Suzanne Ernst, Administrator, Division for Aging Services, Department of Human Resources, 340 N 11th St, Suite 114, Las Vegas, NV 89101; (702) 486-3545.

Dale Capurro, Director, Adult Protective Services, Department of Human Resources, Welfare Division—Medicaid, Capitol Complex, 2527 N Carson St, Carson City, NV 89710; **(702) 687-4588.**

New Hampshire

Elder Abuse Hot Line: In state: **(800) 852-3345;** Richard Chevrefils, Director, Division of Elderly Adult Services, 6 Hazen Dr, Concord, NH 03301-6501; **(603) 271-4680.**

New Jersey

Elder Abuse Hot Line: In state: **(800) 792-8820;** Lois Hull, Director, Division on Aging, Department of Community Affairs, South Broad and Front streets, CN807, Trenton, NJ 08625-0807; (609) 292-4833.

Elga Lee, Supervisor, Adult Protective Services, Division of Youth and Family Services, Department of Human Services, 1 S Montgomery St, CN717, Trenton, NJ 08625; **609 292-6726.**

New Mexico

Elder Abuse Hot Line: In state: **(800) 432-6217;** Michelle Lujan Grishan, Director, State Agency on Aging, LaVilla Rivera Bldg, 4th Floor, 224 E Palace Ave, Santa Fe, NM 87501, (505) 827-7640.

Shelley Gallegos, Bureau Chief, Adult Services Bureau, Social Services Division, Human Services Department, PO Box 2348, Pollon Bldg, Santa Fe, NM 87504-2348; **(505) 827-8402.**

New York

Jane Gould, Director, Office for the Aging, Agency Bldg 2, New York State Plaza, Albany, NY 12223; (518) 474-4425.

Greg Guiliano, Director, Bureau of Community Services, State Department of Social Services, 40 N Pearl St, Albany, NY 12243; **(518) 432-2980.**

North Carolina

Elder Abuse Hot Line: In state: **(800) 662-7030;** Alfred B. Boyles, Assistant Secretary, Division of Aging, CB 29531, 693 Palmer Dr, Raleigh, NC 27626-0531; (919) 733-3983.

Vicki Kryk, Program Consultant for APS, Adult and Family Services, Division of Social Services, Department of Human Resources, 325 N Salisbury St, Raleigh, NC 27611; **(919) 733-3818.**

North Dakota

Linda Wright, Director, Aging Services Division, Department of Human Services, PO Box 7070, Northbrook Shopping Center, North Washington Street, Bismarck, ND 58507-7070; **(701) 224-2577.**

Ohio

Elder Abuse Hot Line: In state: **(800) 686-1581;** Judith Brachman, Director, Department of Aging, 50 W Broad St, 9th Floor, Columbus, OH 43266-0501; (614) 466-5500.

Erika Taylor, Chief, Bureau of Adult Services, Division of Adult and Child Care Services, Family, Children, and Adult Services, Department of Human Services, 30 E Broad St, Columbus, OH 43266-0423; **(614) 466-0995.**

Oklahoma

Elder Abuse Hot Line: In state: **(800) 522-3511;** Roy Keen, Division Administrator, Aging Services Division, Department of Human Ser-

vices, PO Box 25352, Oklahoma City, OK 73125; (405) 521-2327.

Barbara Kidder, Program Supervisor, Adult Protective Services, Aging Services Division, Department of Human Services, 312 NE 28th St, Oklahoma City, OK 73105; **(405) 521-3660.**

Oregon

Elder Abuse Hot Line: In state: **(800) 232-3020;** Jim Wilson, Acting Administrator, Senior and Disabled Services Division, 313 Public Service Bldg, Salem, OR 97310; (503) 378-4728.

Aileen Kaye, Program Manager, Abuse and Protective Services, Senior Services Division, Department of Human Resources, 313 Public Service Bldg, Salem, OR 97310; **(503) 378-3751.**

Pennsylvania

Fraud and Abuse Hot Line: In state: **(800) 992-2433;** Linda Rhodes, Secretary, Department of Aging, 231 State St, Harrisburg, PA 17101-1195; (717) 783-1550.

James L. Bubb, Jr, Aging Services Specialist, Department of Aging, 231 State St, Harrisburg, PA 17101-1195; **(717) 783-6007.**

Puerto Rico

Celia E. Cintron, Executive Director, Governor's Office for Elderly Affairs, Corbian Plaza, Stop 23, 1063 Ponce De Leon Ave, UM Office C, San Ture, PR 00908; (809) 721-5710.

Maria I. Soldevila, Program Director, Services to Adults, Department of Social Services, PO Box 11398, Fernandez Juncos Station, Santurce, PR 00910; **(809) 723-2127.**

Rhode Island

Elder Abuse Hot Line: In state: **(800) 322-2880;** Robert F. McCaffrey, Administrator, Adult Services, Department of Human Services, 600 New London Ave, Cranston, RI 02920; (401) 464-2651.

Maureen Maigret, Director, Department of Elderly Affairs, 160 Pine St, Providence, RI 02903-3708; **(401) 277-2858; (401) 277-2880.**

South Carolina

Ruth Seigler, Director, Commission on Aging, 400 Arbor Lake Dr, Suite B-500, Columbia, SC 29223; (803) 735-0210.

Tim Cash, Director, Division of Adult Services, Office of Children, Family, and Adult Services, Department of Social Services, PO Box 1520, Columbia, SC 29202-1520; **(803) 734-5670.**

South Dakota

Gail Ferris, Director, Office of Adult Services and Aging, Kneip Bldg, 700 N Illinois St, Pierre, SD 57501; **(605) 773-3656.**

Tennessee

Emily Wiseman, Director, Commission on Aging, 706 Church St, Suite 201, Nashville, TN 37243-0860; (615) 741-2056.

Marilyn Whalen, Program Manager, Adult Protective Services, Social Services Programs, Department of Human Services, Citizens Plaza, 400 Deaderick St, Nashville, TN 37219; **(615) 741-5926.**

Texas

Elder Abuse Hot Line: In state: **(800) 252-5400;** Mary Sapp, Executive Director, Department on Aging, PO Box 12786, Capitol Station, 1949 IH 35 S, Austin, TX 78741-3702; (512) 444-2727.

Judith Rouse, Director, Adult Protective Services, Department of Human Services, PO Box 149030, Austin, TX 78714-9030; **(512) 450-3211.**

Utah

Robin Arnold-Williams, Director, Division of Aging and Adult Services, Department of Social Services, 120 N, 200 W, PO Box 45500, Salt Lake City, UT 84145-0500; **(801) 538-3910.**

Vermont

Elder Abuse Hot Line: In state: **(800) 564-1612;** Lawrence Crist, Commissioner, Aging and Disabilities, Ladd Hall, 103 S Main St, Waterbury, VT 05676, (802) 241-2400.

Mark Schroeter, Chief, Adult Protective Services, Aging and Disabilities, Ladd Hall, 103 S Main St, Waterbury, VT 05676; **(802) 241-2345.**

Virginia

Thelma Bland, Commissioner, Department for the Aging, 700 Centre, 10th Floor, 700 E Franklin St, Richmond, VA 23219-2327; (804) 225-2271.

Joy Duke, Program Supervisor, Adult Protective Services, Bureau of Adult and Family Services, Division of Service Programs, Department of Social Services, 8007 Discovery Dr, Richmond, VA 23229-8699; **(804) 662-9241.**

Washington

Charles Reed, Assistant Secretary, Aging and Adult Services Administration, Department of Social and Health Services, PO Box 45050, Olympia, WA 98504-5050; (206) 586-3768.

Vicki Loyer, APS Program Manager, Adult Protective Services Program, Department of Social and Health Services, 623 Eighth SE, Olympia, WA 98504-0095; **(206) 753-5227.**

West Virginia

Elder Abuse Hot Line: In state: **(800) 352-6513;** David K. Brown, Executive Director, Commission on Aging, Holly Grove–State Capitol,

Charleston, WV 25305; (304) 558-3317.

Ronald Nestor, Director, Services to the Aged, Blind, and Disabled, Social Services Bureau, Department of Human Services, State Capitol Complex, Bldg 6, Room B850, Charleston, WV 25305; **(304) 558-7980.**

Wisconsin

Donna McDowell, Director, Bureau of Aging, Division of Community Services, 217 S Hamilton St, Suite 300, Madison, WI 53707; **(608) 266-2536).**

Wyoming

Elder Abuse Hot Line: In state: **(800) 528-3396;** Morris Gardner, Administrator, Commission on Aging, 139 Hathaway Bldg, Cheyenne, WY 82002-0710; (307) 777-7986.

Joe Nies, Program Manager, Family Services, Division of Public Assistance and Social Services, Department of Health and Social Services, 139 Hathaway Bldg, Cheyenne, WY 82002-0710; **(307) 777-6082.**

STATE LONG-TERM–CARE OMBUDSMAN PROGRAM DIRECTORS

The following numbers should be used for assistance in evaluating potential abuse and neglect in institutions.

Alabama

Marie Tomlin, Commission on Aging, RSA Plaza, Suite 470, 770 Washington Ave, Montgomery, AL 36130; **(205) 242-5743.**

Alaska

William O'Connor, Office of the Long-term–Care Ombudsman, Older Alaskans Commission, 3601 C St, Suite 260, Anchorage, AK 99503-5209; **(907) 563-6993** (accepts collect calls from older persons).

Arizona

Rosalind Webster, Aging and Adult Administration, PO Box 6123-950A, 1789 W Jefferson 950A, Phoenix, AZ 85007; **(602) 542-4446.**

Arkansas

Raymond Harvey, Division of Aging and Adult Services, 1417 Donaghey Plaza S, PO Box 1437, Seventh and Main streets, Little Rock, AR 72203-1437; **(501) 682-2441.**

California

Sterling Boyer, Department on Aging, 1600 K St, Sacramento, CA 95814; **(916) 323-6681; (800) 231-4024.**

Colorado

Virginia Fraser, The Legal Center, 455 Sherman St, Suite 130, Denver, CO 80203; **(303) 722-0300; (800) 332-6356.**

Connecticut

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