In this article, we describe the Illinois statewide elder abuse social service program, which is unusual in its comprehensive approach to the assessment and documentation of reported cases of abuse and its extensive data monitoring system. Descriptive information on the number and types of cases of elder abuse reported to the system are presented, along with information on the amount of social work time and administrative effort spent on substantiating abuse reports and providing services. Financial exploitation, emotional abuse, and neglect were the most common types of abuse reported, although emotional abuse was the type most frequently substantiated. The most frequent reasons for case closure were (a) victim entered long-term care, and (b) the workers' assessment that the victim was not at risk for future abuse. A detailed description of the comprehensive assessment and substantiation process is provided.

Key Words: Elder abuse, Family violence, Neglect, Risk factors, Social services

The Illinois Elder Abuse System: Program Description and Administrative Findings

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Millions of elderly citizens have received services provided as a result of the Older Americans Act (Older Americans Act of 1965), the purpose of which was to assist them in maintaining independence and dignity. One form of maintaining independence and dignity is protection from elder abuse. The 1987 Amendments to the Older Americans Act (P.L. 100-175) created a separate provision entitled, Elder Abuse Prevention Activities (title III, Part C). This authority mandates that states develop public education and outreach activities to identify abuse, neglect, or exploitation, as well as procedures for the receipt and investigation of such reports (Benoit, 1991).

In 1990, the National Aging Resource Center on Elder Abuse convened an expert panel of researchers to formulate an elder abuse research agenda. Among other recommendations, the panel noted a need for: (a) more information on the nature and extent of elder abuse; and (b) outcome studies that evaluate adult protective services agencies with responsibility for intervention efforts (Stein, 1991). To date, there is little reported research on the outcomes relating to elder abuse investigations. Knowledge of the indicators of each type of elder abuse is limited, largely due to the problem of collecting valid and reliable data. With the exception of Pillemer & Finkelhor’s (1988) prevalence survey in the Boston area, studies of elder abuse have been limited by small sample sizes (e.g., Block & Sinnott, 1979; Pavesa et al., 1992; Pedrick-Cornell & Gelles, 1982; Ramsey-Klawsnik, 1991), limiting their generalizability and the power to examine differences among types of elder abuse (U.S. Department of Health and Human Services [U.S. DHHS], 1992).

This article describes the Illinois statewide elder abuse social service program, which is unusual in its comprehensive approach to the assessment and documentation of reported cases of abuse. The state of Illinois has a model elder abuse program, which since October 1989, has maintained an extensive computerized data monitoring system. The large number of reports of abuse detailed in this case monitoring system permit an estimation of the social service response to complaints of abuse. Descriptive information on the number and types of cases of elder abuse reported to the system are presented, along with information on the amount of social work, time, and administrative effort spent on substantiating and providing services.

The Statewide Elder Abuse Program

The statewide elder abuse program described in this article is managed by the Illinois State Unit on Aging (SUA), which defines elder abuse as physical abuse, sexual abuse, emotional abuse, confinement, passive neglect, willful deprivation, and financial exploitation. Self-neglect is not included because these cases are managed through a statewide case management program. The SUA’s elder abuse program covers domestic settings only; the State Long-Term Care Ombudsman Office receives and responds to complaints of abuse in long-term care settings.
The Illinois elder abuse program is mandated by state legislation to receive reports of suspected elder abuse, investigate reports, and serve victims. Reporting of suspected elder abuse is voluntary in Illinois (i.e., professionals are not legally required to report suspected abuse). The responsibility of investigating and serving victims is subcontracted by the SUA to private nonprofit elder abuse agencies located throughout the state. These agencies receive and investigate local abuse reports and provide social services as needed when available. The SUA trains and monitors these agencies through its network of Area Agencies on Aging throughout the state.

The caseworkers in each locally situated elder abuse agency are responsible for receiving and investigating reports of abuse, neglect, or exploitation (ANE), and the management of services to ANE victims or abusers. These caseworkers are professional social workers or nurses and are required to participate in a standardized training program leading to certification as elder abuse workers by the SUA. The training, which reflects the philosophy and approach discussed in Hwalek (1989), is comprehensive and includes several stages. Workers are first trained in needs assessment and available social services. Following this, a three-day program provides training on elder abuse investigation techniques, collection and documentation of evidence, and the process of substantiating abuse. The agenda for the first training day covers the following topics: overview of the training, description of the statewide elder abuse program, ethical and emotional issues of elder abuse workers, the intake process, and preparation for the assessment. The second training day covers preparing for the assessment — legal issues, preparing for the assessment — clinical issues, conducting the investigation, and documenting the investigation. The third day begins with a review of the material previously covered and proceeds with a discussion of intervention techniques, closing a case, follow-up, the statewide data base, and completing the data collection forms. The training includes considerable discussion on filling out the data collection forms that provide the data for this report. Subsequent in-service training is also provided.

Through the Illinois SUA’s system of assessment, follow-up, and statewide certification training program, comprehensive and standardized data are collected describing elderly victims and abuser(s) during the initial investigation/assessment process and every three months until case closure. The statewide data base (referred to as ANETS: Abuse, Neglect and Exploitation Tracking System) also contains summary information about the geographic location of the case, demographic data on the victim and abuser(s), and services provided 90 days after intake.

Methods

Sample

The sample for this study was drawn from the population of 3,727 reports of elder abuse, neglect, or exploitation in noninstitutional settings received by the SUA’s statewide elder abuse system between October 1989 and December 1991. The computerized records of these abuse reports were available from the ANETS database. Of the 3,727 complaints of abuse reported to 39 agencies during these first 27 months of the program, 2,577 were substantiated. The subset of 552 reports of abuse that were substantiated and closed by March 1992 are the focus of this report.

Data

The majority of data for this study were obtained from the Illinois ANETS database. To augment the ANETS data, a record review was conducted on the 552 cases of substantiated abuse that had been closed by March 1992. Data reflecting caseworkers’ activities were abstracted from 537, or 97%, of the 552 closed, substantiated abuse records. Five types of information were abstracted from these 537 client files: (a) caseworker time spent per case, (b) each type of “encounter” with the case (e.g., telephone calls, face-to-face meetings, and preparatory types of activities), (c) the types of services provided and refused, (d) the caseworker’s clinical judgment of the probability of future abuse based on specific risk indicators, and (e) the specific types of danger in the reported victim’s situation.

Prior to abstracting these data, a sample of eligible cases was identified and used for pilot testing the data abstraction methodology. Data abstraction instructions were developed, and two members of the data collection team abstracted the aforementioned data from the same 10 cases. The inter-rater agreement of the cases was over 90%. Further, for every case, data abstraction was validated by a second rater. When differences were found, the original case file was reviewed and necessary corrections were made.

Instruments

The implementation of the SUA’s elder abuse system has resulted in the mandatory use of several data collection forms. Between the data contained in the ANETS and the data abstracted directly from the case files, the following five instruments were the sources of data for this study. Note that this documentation is completed by the elder abuse worker for each reported case of ANE, except for the assessment of the probability of future abuse and the care plan, which are only completed on substantiated cases.

1. The intake report is completed by the local agency receiving a complaint of suspected ANE. This instrument collects information about the alleged victim, the alleged abuser, the reporter of suspected abuse, the agency to whom the report was referred, and the content of the report of suspected abuse. A three-level priority code is assigned to the case: 1 = intervention required within 24 hours; 2 = intervention required within 72 hours; and 3 = intervention required within 7 days.

2. An investigation report is completed on all com-
plaints of elder abuse, neglect, or exploitation. It provides information in five general areas:

(a) The victim’s demographic characteristics, legal status, living arrangements, mental competency and barriers to self-sufficiency.

(b) The abuser(s)’ demographic characteristics, legal status relative to the victim, barriers to self-sufficiency, and status as caregiver.

(c) The types of abuse substantiated (physical, sexual, emotional, confinement, passive neglect, willful deprivation, financial exploitation). The substantiation decision involves both the worker and a supervisor.

(d) Up to five specific indicators identified during the investigation for each type of elder abuse, neglect, or exploitation substantiated. A complete listing of these indicators is presented in Appendix A.

(e) The “status” of the case at the close of investigation refers to whether or not the reported abuse was substantiated. For those substantiated cases of abuse, the reason for closure will be one of the following six reasons: (a) victim refuses services, (b) victim deceased, (c) victim entered long-term care, (d) victim moved from area, (e) victim is no longer at risk, and (f) administrative closure (which occurs if there have been no additional reports after 15 months).

3. The case reporting form is used for a chronological, narrative documentation of events related to the investigation, assessment, and intervention with the case. Of particular interest to this research is the caseworker’s record of the amount of time spent on each activity related to the case, such as phone calls, home visits, meetings, and documentation. The total time spent on each case provides an estimate of the intensity of casework services provided to each victim.

4. The care plan logs the types of services needed and provided, and if not provided, whether this was because they were unavailable or refused by the victim. A new form is completed each time services are added or deleted. The 14 types of service categories included on the care plan are income support/material aid, institutional placement, mental health, in-home health, socialization, nutrition, case work, housing, medical, legal, supervision, education, transportation, and other.

5. The risk of future ANE assessment form guides workers’ evaluation of the probability of future abuse. At intake, every three months thereafter, and at the termination of the investigation, the caseworker completes the ANE risk assessment form. Twenty-three predictors of future abuse are organized into five categories: (a) client factors, (b) environmental factors, (c) transportation and support system, (d) current and historic factors, and (e) perpetrator factors. This form is based on the risk assessment protocol developed by the Florida Adult Protective Services. It appears to have content validity for describing the risk of future harm or injury resulting from further abuse, neglect, or exploitation.

Using the Risk of Future ANE form, the caseworker categorizes the victim’s status on the 23 items into one of three groups, which correspond to a three-level probability of future abuse (where 1 = overall, the situation is not likely to recur or to escalate in severity; 2 = in general, there is some possibility that the situation will continue and possibly escalate; 3 = it is very likely the situation will continue and probably escalate in the future (Appendix B). After making a judgment of the probability of future abuse based on these 23 items, the caseworker also makes a global clinical judgment of the risk of future abuse using the same 3-point scale.

To evaluate the quality of these data, an examination of the amount of data missing for each of the 23 abuse risk variables was performed. Figure 1 indicates very little missing data for most variables, particularly those that describe the client background and history, the environment, and support services. However, approximately 30% of the data on the (alleged) perpetrator’s substance abuse, mental and physical health, and stress levels were missing at the intake assessment. Among the victim factors, substance abuse was the most likely variable to have missing data.

Results

Table 1 shows the types of abuse reported and substantiated. Of 3,727 reported cases, financial exploitation was the most frequently reported abuse (49%), followed by emotional abuse (36%), and neglect (33%). As Table 1 shows, the rate of substantiation varies by type of abuse. Reported emotional abuse was substantiated 77% of the time, whereas alleged sexual abuse was substantiated in only 21% of the reported cases.

Figure 2 illustrates the priority score at intake for each type of abuse. Sexual abuse has the highest percentage (40%) of the priority 1 (intervention required within 24 hours) designations. Twenty percent or more of deprivation, physical abuse, and confinement cases are also likely to receive a priority 1 designation. The relatively low percentage of priority 1 designations for financial exploitation is a function of the SUA’s policy to assign priority 3 to almost all cases of exploitation, unless there are also other types of abuse or neglect involved.

Table 2 shows the amount of time spent on substantiated elder abuse cases by the types of social worker activities. The mean number of minutes spent in “pre-substantiation activities” (which include face-to-face visits, telephone calls, and preparatory work was 388 (SD = 282), with a minimum of 80 minutes and a maximum of 2,465 minutes (41 hours). The mean number of minutes workers spent working on cases after substantiation was 668 (about 11 hours), which had a maximum of 5,697 minutes (95 hours).

Table 3 illustrates the distribution of the number of days cases remained open. Twenty-four percent were open 61 to 90 days; 47% were open 91 to 120 days; and 13% were open for more than 150 days. Less than 1% were open for two weeks or less.

Table 4 presents the distribution of types of services needed and provided to victims, as well as the
Table 1. Reports of Abuse and the Percent Substantiated

<table>
<thead>
<tr>
<th>Abuse Type</th>
<th>Number of Reports</th>
<th>Percent of Reports</th>
<th>Percent Substantiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>825</td>
<td>22</td>
<td>61</td>
</tr>
<tr>
<td>Sexual</td>
<td>81</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Emotional</td>
<td>1,350</td>
<td>36</td>
<td>77</td>
</tr>
<tr>
<td>Confinement</td>
<td>256</td>
<td>7</td>
<td>36</td>
</tr>
<tr>
<td>Passive neglect</td>
<td>1,241</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>Willful deprivation</td>
<td>447</td>
<td>12</td>
<td>44</td>
</tr>
<tr>
<td>Financial exploitation</td>
<td>1,817</td>
<td>49</td>
<td>66</td>
</tr>
</tbody>
</table>

Note: N = 3,727. Substantiated cases include those cases where the reported abuse is assessed by the caseworkers as "verified," or as well as having "some indication." Totals add to more than 100% due to multiple types of abuse present within cases and multiple reports of abuse.

number and percentage of services that were refused by victims. The situations in which clients were considered to need a service, yet were not receiving it, were usually the result of client refusal. Clients were most likely to refuse housing assistance, in-home assistance, and mental health services, which included substance abuse treatment. Further analysis of the mental health services most often provided indicated that counseling was the most frequent mental health service provided (10%; data not shown). Substance abuse services were provided to only .1% of victims and .4% of abusers.

Table 5 shows the distribution of reasons for case closure. Twenty-nine percent of cases are closed because the victim entered long-term care. In 24% of case closures, the victim was assessed to no longer be at risk. Victims refused services in 20% of case closures, and were deceased in 16%.

Table 6 presents the probable risk of future abuse as assessed at intake with the same measure at case closure. Almost all cases (97%) with an initial assessment of a low probability of future abuse also closed with a low risk of abuse score. Of the cases assessed at intake with either a moderate or high probability of future abuse, 75% showed a reduction in risk at case closure. Fifty-two percent of cases with an initial moderate risk score had a reduced risk by case closure. Fifty-seven percent of cases initially assessed as having a high risk of future abuse had risk reductions at closure. Forty-four percent changed from high to low risk, while 13% changed from a high to moderate risk.

Forty-four percent of cases initially at high risk remained at high risk at case closure. The reasons for case closure among these 42 cases were as follows: Victim entered long-term care facility (41%); victim deceased (26%); victim refused assistance (21%); and victim moved (12%; these data not shown). Thus, most of the cases that leave the program still at high risk were terminated for reasons beyond the control of the caseworker.

Discussion

This report described a statewide elder abuse program with a client tracking system that allows for the description and measurement of intake, investiga-
I. Type of Reported Abuse

Figure 2. Priority classification at intake by type of abuse (n = 3,727).

Table 2. Caseworker Time (in minutes) Spent on Substantiated Elder Abuse Cases

<table>
<thead>
<tr>
<th>Caseworker Activities</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Substantiation Activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face visits</td>
<td>15</td>
<td>2,060</td>
<td>173</td>
<td>135</td>
<td>159</td>
</tr>
<tr>
<td>Telephone calls</td>
<td>1</td>
<td>715</td>
<td>105</td>
<td>65</td>
<td>108</td>
</tr>
<tr>
<td>Preparatory</td>
<td>5</td>
<td>575</td>
<td>71</td>
<td>45</td>
<td>73</td>
</tr>
<tr>
<td>Total time</td>
<td>80</td>
<td>2,465</td>
<td>388</td>
<td>315</td>
<td>282</td>
</tr>
<tr>
<td><strong>Post-Substantiation Activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face-to-face visits</td>
<td>5</td>
<td>2,545</td>
<td>271</td>
<td>150</td>
<td>320</td>
</tr>
<tr>
<td>Telephone calls</td>
<td>5</td>
<td>3,267</td>
<td>145</td>
<td>82</td>
<td>235</td>
</tr>
<tr>
<td>Preparatory</td>
<td>1</td>
<td>1,395</td>
<td>112</td>
<td>60</td>
<td>150</td>
</tr>
<tr>
<td>Total time</td>
<td>35</td>
<td>5,697</td>
<td>668</td>
<td>440</td>
<td>689</td>
</tr>
</tbody>
</table>

Note: Preparatory time includes activities such as team meetings and preparation of documentation. N = 529 because 8 of the 537 closed substantiated cases had missing data on these variables.

A major finding of the evaluation of the SUA’s elder abuse program is the high quality data described in this report. It is significant that a group of geographically disparate professional elder abuse caseworkers who work for independent agencies have found it feasible to collect and provide extensive and relatively complete data as part of their routine case investigation and service provision activities. The investigation process requires extensive face-to-face contact with the victims and the victim’s active involvement in the case. Thus, the Illinois investigative approach to reports of ANE is likely to be more sensitive than other methods that may rely more heavily on telephone-based investigations. The high quality of the ANETS database suggests that it is feasible to combine evaluation and outcome research with the practical aspects of case investigation and administration conducted by independent agencies under the supervision of the SUA.

It was somewhat surprising to find that financial exploitation was the most frequent type of abuse.
reported. Although others have noted that financial exploitation is a common type of elder abuse (Ogg & Bennett, 1992; Podnieks & Pillemer, 1989), Rowe, Davies, Baburaj, and Sinha (1993) reported it likely is underestimated, particularly among those with dementia. Possible contributors to the relatively high prevalence of reports of financial abuse in Illinois may include the fact that many programs in other states have only recently begun to include financial abuse as a subtype of abuse, and others do not include it at all. In addition, reports of financial exploitation are likely bolstered by the fact that elder abuse services in Illinois are available to all residents age 60 and over, whereas some states only provide such services to elderly persons with disabilities.

There was great variation in the rates of substantiation of different types of abuse. Although emotional abuse was the most frequently substantiated (77%), the majority of reports of physical abuse, neglect, and financial exploitation were also substantiated by caseworkers. Sharon (1991) studied rates of substantiation of abuse and neglect reports in 2,489 cases reported to the Wisconsin statewide elder abuse reporting system. He found that 57.1% of reports of physical abuse were substantiated, as were 55.8% of reports of emotional abuse, 43.8% of neglect reports, and 43.7% of material abuse reports. He did not report on sexual abuse, confinement, or willful deprivation. He also reported on factors that were related to substantiation. Reports from urban areas, and those cases in which abusers were relatives, were more likely to be substantiated. In addition, substantiation was greater when victims and/or abusers had disabilities, chronic diseases, and substance abuse problems. Reports involving financially dependent abusers were less likely to be substantiated.

Although sexual abuse was assigned the highest priority level at intake, it was the abuse least likely to be substantiated. Substantiating sexual abuse is particularly problematic due to the nature of the issue, which is likely to involve feelings of shame, denial, and a reluctance to disclose. Sexual abuse is unlikely to involve witnesses for corroboration. It may also be the abuse type that is most difficult for the social worker to discuss as well (Holt, 1993). Program administrators would be wise to recognize that caseworkers may not be comfortable investigating sexual abuse and will need sensitive training to promote the adequate investigation of reports of sexual abuse (Ramsey-Klawsnik, 1993).

Another element of the system — data on the worker time expended in receiving reports, investigating reports, assessing victims, and serving cases — presents valuable information for deriving cost estimates and staffing patterns. As would be expected, elder abuse investigations are quite variable in the amount of worker time and effort; some extreme cases required over 80 hours of worker effort. The effectiveness of these highly trained caseworkers was suggested by the data that showed the major-
ity of cases that were initially at moderate or high risk for future abuse were closed with a reduction in the probability of future abuse.

The use of evaluation systems in the management of nonprofit agencies was advocated by Gray (1993) when describing a new vision for evaluation. The data available through the ANETS information system provides a feedback mechanism to program decision makers concerned with implementing a comprehensive elder abuse detection and intervention program. The use of evaluation data for frequent program monitoring provides a systematic means of understanding how the program is operating, whom the program is serving, and problem areas that hamper effectiveness. The utility of the substantiation of abuse as an outcome variable needs further exploration. Sharon (1991) has questioned whether substantiation can be used to predict further case outcomes, or whether it is best used as a measure of accuracy in reporting. He found substantiation was a possible predictor of service offering and acceptance only in the areas of inpatient and nursing home placement.

Several limitations to the ANETS database are important to mention. First, the instrument to assess the Risk of Future ANE needs empirical validation. Although it appears to have content validity and is used in at least two statewide elder abuse programs, it has not been subjected to a rigorous validation study. In addition, the future risk of abuse variable, with only three levels (low, moderate, and high), has limited sensitivity. The SUA is considering increasing the range to a five-point scale, because a larger range of scores will make it possible to detect more subtle changes in risk status.

Although the overall quality of the ANETS database is quite good, the amount of missing data relating to the abuser was disappointing. Several factors were likely to contribute to the missing data on abusers. First, all interviews with possible sources of information require the abused client's consent, and in some cases, victims refused to authorize workers to talk to their abusers. In other cases, the abuser was either unavailable or refused to provide information. There are also safety considerations for both the client and social worker in dealing with perpetrators. Because this report is from the initial inception of the program, with increasing experience, workers may be more successful in obtaining information from abusers.

The ANETS system does not track the outcome of cases that were referred for legal services because the SUA does not currently have a systematic procedure for the follow-up of cases that are referred to the State Attorney's office for prosecution. Once so referred, the case is out of the SUA's control, and it is difficult to follow these cases because of the slow nature of the legal system, as well the possibility that accused abusers may plea bargain and admit guilt to a lesser charge. In addition, the myriad barriers to prosecution make this an unlikely outcome in elder abuse (Korbin, Anetzberger, Thomasson, & Austin, 1991). In spite of these issues, plans are under development in the Illinois system to collect data on whether referred cases actually go to court, along with their final disposition.

Finally, an exploration of the generalizability of these data is needed. A particular issue is that the data presented reflect the initial 27 months of the statewide program. This initial period of data collection incorporates the expected learning curve of data collection procedures, as well as the inclusion of some long-standing cases of reported abuse that were "grandfathered" into the system once it became operational. As such, the profile of administrative effort, services provided, and victim risk status presented may change when compared with future years' data that will more accurately reflect the operation of the current SUA's operating policies and procedures.

References


Received April 7, 1995

Accepted October 7, 1995

Appendix A. Abuse Indicators by Type of Abuse

Indicators of Physical Abuse (defined as causing the infliction of physical pain or injury)

Injuries: cuts, bites, punctures, abrasions, lacerations, bleeding, sprains, dislocations, bone fractures, bruises, burns

Injuries:

- cuts
- bites
- punctures
- abrasions
- lacerations
- bleeding
- sprains
- dislocations
- bone fractures
- bruises
- burns
Pattern of injuries: repeated, frequent, unusually placed, several at one time, various stages of healing, bilateral, upper arms, clustered, inflicted with familiar object
Violent actions against elder: pushed, shoved, grabbed, shaken, choked, slapped, punched, hit, kicked, beaten, cut, shot, handled roughly, force fed
Inappropriate chemical restraint: overmedicated, not checked for side effects of medication, too much alcohol, medication without reason
Medical evidence: skeletal injuries, retinal hemor-

hages/detachment, unsevered fractured bones, duodenal/jejunal hematomas, ruptured inferior vena cava, peritonitis, internal injuries

Indicators of Sexual Abuse (defined as touching, fondling, or any sexual activities with an older person when that person is unable to understand or to give consent, or is physically forced to engage in sexual behavior)
Medical evidence: presence of semen; pharyngeal gonorrhea
Behaviors of victim: flirtation with abuser, coziness with abuser, inappropriate relationship with abuser
Violent actions against elder: sexually assaulted, forced to perform oral sex

Indicators of Emotional Abuse (defined as verbal assaults, threats of abuse, harassment, or intimidation so as to compel the older person to engage in conduct from which he or she has a right to abstain or to refrain from conduct in which the older person has a right to engage)
Actions of abuser: uses harsh tone of voice; swears at elder; talks of elder's death; talks of elder as a burden; threatens elder with violence, institutionalization, guardianship, abandon
dment, premature discontinuation of a person other than the older person)

Indicators of Confinement (defined as restraining or isolating an older person for other than medical reasons)
Inappropriate physical restraint: tied to furniture, gagged, locked in room, no adequate padding, only for confusion, without medical orders, without trying alternatives, not periodically checked, not permitted to leave house

Indicators of Neglect (defined as failure of caregiver to provide an older person with the necessities of life because of failure to understand (passive) or willful denial (willful deprivation)
Improper hygiene: odorous/not bathed, uncut hair, unshaven, overgrown toe/nail
Skin: abrasions, untreated sores, insect bites, lesions, dirty, dry, rash
Nutrition: dehydrated, malnourished, constantly hungry, not fed, inadequate meals
Physical care of victim: not wearing clothes/shoes, shoes on wrong feet, inadequate clothing, inappropriate clothing, dirty, torn clothing, same clothing all the time, inappropriate physical restraint, left alone for long periods, lying in feces/urine, lying in old food
Behaviors of victim: begging for food, stealing food, eats meals alone in room, picking at sores, scratching self with nails/instruments
Social isolation: victim feels rejected, victim left alone, no opportunity to be with others, no planned activities, no cognitive stimulation
Medical care of victim: not receiving medical care, no walking aids when needed, therapeutic diet not followed, no false teeth when needed, decayed teeth, no glasses when needed/broken glasses, no hearing aid when needed/broken aid

Conditions of home: home in bad disrepair, extremely dirty/garbage piled up, vermin/rats/lice/cockroaches, offensive odors, not enough heat/no fuel, heat/electricity cut off, inadequate heating system, contaminated water, no water supply, no refrigerator, no stove
Behaviors of abuser: withholds food or medications, does not assist with toileting, does not assist with eating when needed, call bell out of reach/refuses to answer, uses several medical facilities, ignores/will not talk to victim, gives care mechanistically

Indicators of Exploitation (defined as misuse or withholding of an older person's resources by another to the disadvantage of the elderly person and/or the profit or advantage of a person other than the older person)
Unusual or inappropriate bank activities of victim: signs checks to someone else; signs checking account to someone else; does not sign for withdrawals; depletes bank account; unaware of reason for seeing banker; unaware of reason for seeing attorney; assets do not match standard of living; put someone on bank accounts; put someone on stocks, bonds, investments; loans money with no repayment plan
Unusual case transactions or behaviors of victim: Social Security check missing, out of money, unaware of monthly income, frequently missing check book, made unusually large gift, unpaid bills when income is adequate

Inappropriate decision making by abuser: victim put under unneeded guardianship, executed power of attorney unnecessarily, given deed by victim for lifelong caregiving, more interested in money than caregiving

Theft: lost property, lost cash
Abuser controls banking decisions: has access to victim's safe deposit box, always makes bank withdrawals for victim, no receipts for bank withdrawals, draws funds from dormant account, makes all investment decisions, unusually large bank withdrawals
Abuser controls cash: receives victim's checks, wants government checks sent to him or her, cashes checks without paying victim's bills, signatures on checks do not match the victim's, checks signed when victim cannot write, money stolen from victim, property stolen from victim, withholds cash from victim's checks, sells victim's house without permission and/or withholds money from sale, prevents elder from collecting debts, lives with victim but pays no rent, is financially dependent on victim, grossly overcharges victim for residence, takes victim's money for own purposes

Vandalism by abuser: misused property of victim, damaged property of victim
General behavior indicators:
Behaviors of abuser: appears to be cruel, punishes elder more severely than intended, refuses to discuss victim's situation, evasive regarding victim's situation, cannot be located after several tries, refuses needed services, uncooperative with worker, will not let victim be alone with worker, will not let worker in home, will not let victim answer questions, past history of abuse, well dressed when victim is poorly dressed

Statements of abuser: makes threats about or to victim, no reasonable explanation for victim's condition, feels
he or she must punish victim, sees no alternative to
punishment of victim, believes victim will die soon,
disinterested in victim as a person, blames the victim,
has unrealistic expectations of the victim, lacks knowl-
edge of victim’s needs, complains about caring for
victim, has compulsive knowledge of victim’s needs

Statements of victim: states that alleged abuser harmed
him or her, afraid of alleged abuser, afraid of family
member(s), afraid of neighbors, afraid of friends or
visitors, doesn’t want alleged abuser around, has no
friends, feels rejected by family

Statements of others: direct statements about abusive
actions, direct statements about neglectful actions

Patient history: long time between illness onset and
medical care, uses several medical facilities, frequent
use of emergency room, no new lesions during hospita-
tization, injuries not mentioned in history, injuries
incompatible with history

Appendix B. Assessment of Probability of Future Abuse

For each predictor variable, 1 = Overall, the situation is
not likely to recur or to escalate in severity; 2 = In general,
there is some possibility that the situation will continue
and possibly escalate; 3 = It is very likely the situation will
continue and probably escalate in the future.

Client Factors

Age/sex:
1 = women age 60 or fewer years; men age 60 to 74
years;
2 = women age 61 to 74 years;
3 = men or women age 75 and over.

Physical health and/or functional abilities:
1 = Ambulatory, minimal physical disability; capable
of performing activities of daily living.
2 = Diminished capacity; moderate physical disabil-
ity; difficulty ambulating; requires prosthesis
(cane, walker, etc.) or hands-on assistance to be
ambulatory; occasionally nonambulatory.
3 = Severe and functionally limiting disability; bed-
ridden, completely dependent on others, chronic
disease, rapid deterioration of functional
abilities.

Substance abuse and other special problems (e.g., wan-
dering, misuse of medication, noncompliance with phy-
sician’s instructions):
1 = No indication of substance abuse; no or minor
special problems.
2 = Periodic episodes of alcohol or substance abuse.
3 = Active alcoholic or substance abuser; any change
that places the client at high risk.

Income/financial resources:
1 = Adequate; able to provide for the necessities of
life; financially independent of others.
2 = Partially dependent on others financially; mar-
ginal financial resources; barely able to provide
for the necessities of life.
3 = Totally dependent on others financially, or re-
gardless of income unable/unwilling to provide
for the necessities of life.

Environmental Factors

Structural soundness of the home:
1 = Sound structure with no apparent safety
problems.
2 = Deteriorating structure, or safety problems that
pose some degree of risk.
3 = Client living in a structurally unsound or con-
demned structure; gross safety problems.

Appropriateness to the client:
1 = Operating utilities (heat, power, water, ventila-
tion, etc.) appropriate to climate and client’s
health; residence does not contribute to client’s
risk.
2 = Service temporarily terminated or periodic inter-
ruption of heat, power, water, ventilation (un-
vented heaters); residence poses special prob-
lems that place the client at risk (e.g., client wan-
ders and lives near major highway).
3 = Services terminated or utilities inoperative; resi-
dence poses special problems that place the cli-
ent at immediate risk (e.g., nonambulatory client
residing on third floor; client repeatedly victim-
ized by violent crime, residence cannot be made
safe).

Cleanliness of residence:
1 = Residence meets minimum standard of cleanli-
ness; trash not exposed; no odors present.
2 = Trash and garbage not disposed of; animal
droppings and some evidence of pest/rodent
infestation.
3 = Gross health violations (e.g., severe pest/rodent
infestation); human waste present.

Transportation and support system

Availability/access and reliability of services (i.e., trans-
portation, home health, medical, etc.):
1 = Adequate and reliable community resources
available; client able to leave residence on a regu-
lar basis; transportation available.
2 = Limited community services available, or short-
term waiting list; service reliability is problem-
atic; public transportation is unavailable; private
transportation is unavailable; private transporta-
tion is problematic.
3 = Geographically isolated from community ser-
dices; long waiting lists; services unreliable or not
available at frequency required.

Adequacy of formal or informal support network:
1 = Family, friends and neighbors available, willing,
and able to provide or arrange needed services;
has a well-informed, effective advocate; known
to service system; already receiving services.
2 = Family somewhat supportive, but not in geo-
graphic area; limited support from family, friends,
and/or neighbors; support is irregular in quality
and/or frequency; limited or incomplete knowl-
edge of available public or private resources.
3 = Client is socially isolated, with no one available,
willing, or able to provide assistance; no knowl-
edge of formal support system; unable to access
available services; lacks a willing/effective
advocate.

Current and Historical Factors

Severity of physical or psychological abuse:
1 = None, or minor injury limited to bony parts (i.e.,
knees, elbows); no apparent adverse psychologi-
cal effect on client.
2 = Minor or unexplained injury (limited to bony
parts, buttocks, or torso) requiring medical
treatment/diagnosis; pattern of increasing sever-
ity of abuse; client evidencing some adverse psy-
chological effects of abuse (fear, anger, with-
drawal, depression, etc.).
3 = Client requires immediate medical treatment/ hospitalization; any sex abuse or injury to head, face, genitals; escalating pattern of severe abuse; client evidences serious adverse psychological effects of abuse.

Frequency/Severity of exploitation of person or property:
1 = None, or exploitation with little, if any, impact on the client’s health, safety, or well-being.
2 = A pattern of ongoing exploitation that, if unchecked, could threaten the health, safety or well-being of the client.
3 = Any exploitation that threatens the health, safety, or well-being of the client, or deprives the victim of the necessities of life; any systematic misuse of the victim’s resources (e.g., fraud/forgery).

Severity of neglect:
1 = None; isolated, explainable incident, or neglect with little risk to the client.
2 = Deprivation of adequate supervision of basic needs (e.g., medical care, food, shelter, etc.), which if unchecked, will endanger the health and well-being of the client.
3 = Client requires immediate intervention (medical treatment, placement, emergency services, etc.); client is at risk of death or serious harm for lack of adequate supervision or care.

Quality/consistency of care:
1 = Client/caregiver is well informed, responsible, and provides the degree of care required.
2 = Client/caregiver provides care, but knowledge, skills, and abilities or degree of responsibility are problematic and may contribute to risk.
3 = Client is at risk due to self/caregiver irresponsibility or lack of knowledge, skills, and abilities of caregiving; client lives alone and has diminished mental and/or physical capacity.

Previous history of violence, abuse, neglect, or exploitation:
1 = No known history of violence, abuse, neglect or exploitation.
2 = Any previous informal or formal report (law enforcement, medical, etc.) of violence, abuse, neglect, or exploitation.
3 = Ongoing history or pattern of increasing frequency of violence, abuse, neglect, or exploitation; any previous report that led to prosecution or was classified as confirmed or indicated.

Perpetrator Factors
Access to the client:
1 = Never or rarely alone with client; client has frequent, regular contact with others in or out of the household.
2 = Unpredictable presence of others in the home; limited opportunity to be alone with the client; despite allegations, uncertainty if others will deny access to the client.
3 = Complete, unrestricted access to the client.

Situational stress/response to home crisis (e.g., the investigation, recent birth, death, marital difficulties, hospitalization, caregiving responsibilities, unemployment, financial problems):
1 = Realistically adapts and adjusts to situational stress/life crises.
2 = Difficult, prolonged, inappropriate, or unrealistic adjustment to situational stress/life crises (e.g., frustration, fatigue, depression, anger).
3 = Gross overreaction or highly inappropriate reaction to stress/life crises (e.g., severe depression, hopelessness, violation of societal norms); caregiver suffering chronic fatigue.

Physical health:
1 = Good heath or minimal, but controlled or compensated physical difficulties.
2 = Physical handicap and/or episodic physical difficulties; may be in poor health or have a poorly compensated or controlled chronic illness.
3 = Severe and functionally limiting physical disability; chronic or uncontrolled disease; recent, rapid deterioration of physical health.

Mental/emotional health/control:
1 = None, or minimal, but controlled mental or emotional difficulties; responsive to client; realistic expectations of the client; can plan to correct problem.
2 = Periodic mental/emotional difficulties or problems of control; poor reasoning abilities; immature, dependent or has unrealistic expectations; somewhat unresponsive to the client; periodic episodes of alcohol/substance abuse; parasitic, opportunistic behavior.
3 = Severe and functionally limiting mental disability; history of chronic or uncontrolled mental disease; desire to harm the client; overconcern with client’s “bad” behavior; bizarre or violent behavior; suicidal; unresponsive to the client; asks to be relieved; threatens client with hospitalization; recent rapid deterioration of mental/emotional health/control.

Perpetrator/victim dynamics contributing to risk:
1 = Nominal relationship; no apparent fear or reluctance to discuss allegation; no apparent special problems.
2 = Client makes excuses for, or desires to protect the perpetrator because of blood relationship, concern over consequences, guilt, shame, or low self-esteem; victim guarded or reluctant to discuss allegations.
3 = Client fears or has irrational desire to protect the perpetrator; any bond that causes victim or caregiver (if not perpetrator) to tolerate ANE (e.g., victim or caregiver emotionally dependent or obsessed with perpetrator).

Cooperation with investigation:
1 = Aware of the problem; cooperates to resolve problems and protect client.
2 = Minimal cooperation, with constant encouragement/support.
3 = Despite evidence, doesn’t believe there is a problem; refuses to cooperate.

Financial resources/dependency on the client:
1 = Financially independent on, or not wholly dependent on the client for income.
2 = Feels obligated to care for the client by financial necessity or blood relationship; victim or caregiver provides partial or supplementary support; some indication of parasitic/opportunistic behavior.
3 = Perpetrator is financially dependent on victim; history of parasitic/opportunistic behavior.

Substance abuse and other special problems (e.g., wandering, misuse of medication, and noncompliance with physician’s instructions):
1 = No apparent special problems.
2 = Episodic substance/alcohol abuse or other special problems.
3 = Chronic substance abuse/alcoholism or special problems.