MAHNAZ AHMAD, MD, MS
Division of Geriatric Medicine and Gerontology, The Weill Medical College of Cornell University, New York

MARK S. LACHS, MD, MPH*
Division of Geriatric Medicine and Gerontology, The Weill Medical College of Cornell University, New York

Elder abuse and neglect: What physicians can and should do

ABSTRACT

Although reports of elder abuse to official agencies have been steadily increasing, physicians report only 2% of reported cases. Multiple barriers to reporting exist. This article reviews the terminology, epidemiology, and clinical signs associated with elder abuse in the community and offers practical strategies for intervention.

KEY POINTS

Elder abuse encompasses physical, emotional, financial, and sexual abuse, as well as neglect.

Neglect can be passive or active, depending on the intent of the caregiver.

Reporting of elder abuse is inadequate, owing largely to lack of awareness in health care professionals and in society and lack of professional protocols.

A home visit by a home health agency worker is one way to gather information about a potentially abused patient's safety.

SEVENTY-NINE-YEAR-OLD Ms. T is brought to the doctor's office by her son, with whom she lives. She has a history of severe osteoporosis with several compression fractures of the spine. This requires long-term pain control; otherwise she is reported as healthy.

The son reports that his mother used to be highly functional and independent, but not for the past year. He appears very concerned about her health and functional status, and he answers all questions for her. When asked to leave the room so that the patient can be examined, he refuses, saying she would be afraid if left alone in a new place.

Ms. T's appearance is unkempt and her clothes dirty. In the course of discussing the management of Ms. T's clinical situation, the doctor offers help in the form of home health services, but the son refuses.

The doctor suspects that an abusive situation exists, but is unsure how to proceed.

ELDER ABUSE IS COMMON, UNDERREPORTED

Elder abuse is common but little studied and underreported. According to the House Select Committee on Aging,[1] each year between 1 and 2 million older Americans experience mistreatment. Yet, while 75% of hospital emergency departments have protocols for dealing with child abuse, only 27% have elder abuse protocols,[2] reflecting the lack of attention this problem receives from the community in general.

The purpose of this article is to familiarize physicians with the definitions, epidemiology, and clinical findings associated with elder abuse and to suggest practical strategies for intervening.

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TABLE 1

Elder mistreatment: Categories and definitions

Physical
Willful act carried out with the intent of causing pain or injury
Examples: slapping, hitting, kicking, force-feeding, restraint, striking with objects

Emotional
Willful act executed to cause emotional pain, injury, or mental anguish
Examples: verbal aggression or threat, threats of institutionalization, social isolation, humiliating statements

Financial
Misappropriation of an elderly person's assets for personal or monetary gains
Examples: theft of checks or money, or coercion to deprive the elderly person of his or her assets, such as forcible transfer of property

Sexual
Nonconsensual sexual activity with an elderly person
Examples: suggestive talk, forced sexual activity, touching, fondling with a nonconsenting competent or incompetent person

Caregiver neglect
Intentional or unintentional failure of designated caregiver to meet needs necessary for elderly person's physical and mental well-being
Examples: failure to provide adequate food, clothing, shelter, medical care, hygiene, or social stimulation

Miscellaneous
Violation of rights
Examples: abandonment, denial of privacy or participation in decision-making

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Reports to agencies most certainly underestimate the prevalence of elder abuse

DEFINITIONS AND EPIDEMIOLOGY

Elder abuse

Controversy surrounds the term "elder abuse." Other terms often used include "inadequate care of the elderly" and "elder mistreatment."

In 1987, the American Medical Association (AMA)[3] proposed this definition: " 'Abuse' shall mean an act or omission which results in harm or threatened harm to the health or welfare of an elderly person. Abuse includes the intentional infliction of physical or mental injury; sexual abuse; or withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person by one having the care, custody, or responsibility of an elderly person."

The definition of abuse varies by state, since state agencies are charged with the identification and management of these cases.

Most experts believe the definition of abuse should include physical, emotional, financial, and sexual abuse, as well as neglect (TABLE 1). Abuse is also categorized as occurring in the community or an institution. The primary focus of this article is elder abuse in the community (see sidebar on page 804 for an overview of institutional abuse).

Passive and active neglect

Neglect is the intentional or unintentional failure of a caregiver to meet the physical and emotional needs of an elderly person.[4] Caregiver neglect is either passive or active.[5]

Active neglect is the willful failure to provide care.

Passive neglect is the nonwillful failure to provide care, owing to caregiver ignorance, lack of skills, or the caregiver's own failing health. For example, a visually impaired caregiver might not be able to give insulin properly to a diabetic patient.

Self-neglect, another important syndrome that is investigated by state agencies, is conduct by a patient that threatens his or her own health or safety.[6] Advanced cognitive impairment and an inadequate support system can lead to self-neglect when a patient becomes

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unable to care for himself or herself and ends up in a state of complete physical and social breakdown. This may result in impairment of physical health, eg, anemia and malnutrition.

An extreme form of self-neglect is the **Diogenes syndrome,** named for the ancient Greek philosopher who rejected material comforts, went about dirty and dishevelled, and lived in a barrel. Characteristics include domestic squalor, social withdrawal, tendency to hoard garbage, lack of shame, and refusal to accept help. Patients with this syndrome usually live alone. The underlying pathogenesis is postulated to be a lifelong subclinical personality disorder that gradually turns into gross self-neglect and social retreat.

Although self-neglect is fundamentally distinct from elder abuse, clinicians should be aware of the syndrome.

INCIDENCE AND PREVALENCE

The National Center on Elder Abuse[7,8] noted a steady increase in the number of cases of domestic elder abuse reported between 1986 (117,000 cases) and 1996 (293,000 cases). However, reports to official agencies most certainly underestimate the prevalence, owing to various barriers described later in this article.

A widely cited community-based Boston survey[9] revealed a prevalence of 32 cases of elder abuse per 1,000 older adults, with most of those cases involving physical abuse, and with others involving verbal abuse or neglect.

Who are the abusers?

In the Boston survey,[9] the abusers were the victims' spouses in up to 58% of cases, children in 16%, and other relatives in 18%. Male caregivers were more likely to be abusive than female caregivers, but the gender disparities are not large: in some studies women were slightly more frequent perpetrators of elder abuse than men.[10,11] And contrary to popular belief, caregiver stress does not necessarily lead to elder abuse, nor is elder abuse correlated with religion or marital status.[9]

Studies of culture and ethnicity in elder abuse have yielded interesting results. Different ethnic and cultural groups have their own definitions of elder abuse. For example, elderly Asian Americans were much more tolerant of abusive relationships and less likely to seek help.[12] This probably stems from cultural values that emphasize hiding family shame, avoiding conflicts in the family, and promoting tolerance.

The victim's gender is not a factor in elder abuse, although women were previously believed to be victims of abuse more commonly than men.[10,11,13] **TABLE 2** summarizes risk factors for abuse.

TABLE 2

Risk factors for elder abuse

Elder-specific
- Cognitive impairment
- Poor health and functional impairment
- Social isolation
- Shared living arrangement
- Dependence on caregiver

Caregiver-specific
- Substance abuse
- Mental or physical illness
- Financial dependence on the victim
- Stress (divorce, bankruptcy, caregiver burden—in some studies, but not all)
- History of violence

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Ask about abuse as part of the health screening

BARRIERS TO REPORTING ABUSE

Sadly, physicians report only 2% of all reported cases of elder abuse, despite mandatory reporting laws in most states.[14] One study found that family members report 20% of all cases, hospitals 17.3%, and home health aides 9.6%—all higher than the rate for physicians.[15]

Many barriers to reporting of elder abuse have been identified. Some are results of an incomplete and flawed medical education system. Examples[5,16]:

- Uncertainty about the validity of the diagnosis
- Lack of training in recognizing abuse
- Discomfort in confronting the alleged perpetrator
- Fear that the abuser will retaliate against the victim
- Unawareness of procedures for reporting
- Disinclination to be involved in the legal system

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Institutional elder abuse

Institutional elder abuse and neglect are mistreatment that occurs in nursing homes and other congregate living environments for older people. The perpetrators may include staff members, other residents, or visitors.

The forms of mistreatment are similar to those in the community. The difference is the availability of health care providers in the environment to detect mistreatment.

Every state has a means for reporting and investigating alleged mistreatment in nursing homes.

Abusive staff members tend to be younger, less educated, less experienced in working in a nursing home environment, and dissatisfied with their jobs.[21] Nursing aides are more likely to be abusers than are nurses. Institutional characteristics that are risk factors for abusive behavior towards residents include a stressful working situation, staff "burnout," low wages, and lack of training in conflict resolution.

Steps to remedy institutional abuse may include increasing the funding, hiring well-qualified workers, and training in conflict management and stress reduction.[21] Nursing home administrators should report abuse promptly and not wait until internal investigations are completed.[5]

- Hesitancy to "label" the victim or the abuser
- Perception that the proof of abuse is inadequate
- Lack of professional protocols for elder abuse
- Societal perceptions such as ageism
- Lack of public and professional awareness.

Often, caregivers or the victims themselves deny abuse, and family members may attempt to isolate victims from the medical system.[5,16] Detecting elder abuse is challenging because an abusive situation may present itself in a nonsuspicious way, such as a diagnosis of dehydration or failure to thrive.

Interview the caregiver and patient separately, starting with the patient

PHYSICIANS SHOULD REPORT ABUSE

When abuse occurs or is suspected, physicians—indeed, all health care providers—should step up to the task of notifying the proper authorities, even though this may be intimidating to some. In some states, they may be legally required to do so. (Laws vary from state to state, and physicians should clarify the existing law in their own state.[17]) Moreover, although physicians are rarely penalized for not reporting alleged cases of abuse, it should be part of one's moral and professional responsibility.

The primary care physician should also participate in the ongoing management once the case is reported.

Generally, physicians and other reporters are granted immunity when it is believed that the reporting was done in good faith. In some states, mere suspicion of abuse is enough grounds for reporting.[17]

Reports should be made to the local adult protective service agency. In an emergency one may contact the police. Once a report has been filed, a social worker is assigned to the case and makes a home visit. After screening the case and conducting an interview, the social worker suggests solutions and gives information about available resources.

An abused adult with decisional capacity can decline the proposed solution or may request that the physician not disclose information. In the latter situation, a home visit may be offered as an attempt to provide additional helpful services and to gather more information about abuse.

ROUTINELY ASK ABOUT POSSIBLE MISTREATMENT

The AMA recommends that physicians routinely inquire about possible mistreatment of elderly patients,[18] much as they screen for other conditions such as colorectal or breast cancer. Precisely how to ask has not been determined; however, if the questions raise suspicion of an abusive situation, specific steps need to be taken, as outlined below.

Patients may not volunteer information, owing to cognitive impairment or fear of retaliation by the abuser (which includes fear of

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being placed in a nursing home, physical violence, or other retribution). Diminished cognitive capacity does not necessarily mean the patient cannot describe abuse, however.

Generally, the patient and the caregiver should be interviewed separately, and the patient should be interviewed first.[18] This often brings factual discrepancies to light, such as, if the patient has been injured, how he or she got hurt.

Repeat the patient's responses, both to clarify your understanding and to allow the patient to reflect. "You didn't tell anyone because you were afraid that your son would get upset with you. Is that correct?"

General questions such as "Who cooks for you?" or "Do you get help with shopping when you need it?" may pave the path for more targeted queries: "Does your daughter ever hit you when you two have a disagreement?" "Do you have to wait a long time for your food or medicine?" Most physicians are uncomfortable with these specific questions, but they must be asked.

Inquire about abuse in a nonjudgmental way so the person suspected of abuse does not feel threatened. A statement like "You've been carrying a heavy responsibility for some time now and it's all right to feel burdened at times" expresses empathy toward the caregiver and may help establish rapport.

Consider unintentional neglect resulting from the failing health of the caregiver.

Common red flags for abuse include:

- Reluctance of the caregiver to leave the patient alone with the health care provider
- Poor knowledge of the patient's medical conditions
- Missed appointments
- Discrepancy between objective data and what the caregiver says (eg, subtherapeutic levels of medications in the blood when the caregiver says he or she gives the medication as directed)
- Frequent visits to the emergency department, physician's office, or hospital
- "Doctor shopping"
- Delay in seeking medical care
- Different histories given by the patient and the caregiver
- Unexplained injuries.[4,5,18]

CLINICAL PRESENTATION

Physical examination

Physicians should be mindful of findings, presentations, and circumstances that could raise the question of abuse; **TABLE 3** summarizes some common but often missed presentations.

On the other hand, we also need to consider the possibility of making a mistake—either missing a case of abuse or incorrectly diagnosing abuse where none exists. For example, swelling of the hand due to rheumatoid arthritis may resemble trauma, digital ischemia due to Raynaud phenomenon may be confused with burns, a fracture may be the result of osteoporosis and not physical manhandling, and cigarette burns on the mouth may be due to poor functional status and not abuse.[17]

Pressure ulcers merit special mention. They are more common in the frail elderly, owing to limitation of mobility from cerebrovascular accidents, dementia, peripheral neuropathy, and musculoskeletal conditions. The problem is compounded when the caregiver is physically unable to turn the patient every 2 hours to prevent ulcers from developing.

Moreover, caregivers often inappropriately restrain severely demented patients to protect them from wandering into unsafe areas or from falling. Patients may also be restrained to control assaultive behavior, which often accompanies advanced dementia. Pressure ulcers can develop from being tied down for prolonged periods.

The goal is not to punish the abuser but to stop the abuse

Laboratory and radiographic studies should be obtained on the basis of the findings of the history and physical examination. Radiographs can rule out fractures, and blood tests can exclude medical conditions that suggest abuse. For example, a complete blood count and a coagulation study can help when the cause of bruising is in question.

Documentation should be clear and legible because it could become crucial evidence in a court of law. Drawings and color photographs are very helpful in capturing telltale physical findings for this purpose.[19]

MANAGEMENT

A multidisciplinary team, including a nurse, psychiatrist, social worker, legal representa-

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TABLE 3

Physical findings that suggest elder abuse or neglect

General appearance
Poor hygiene, dirty clothing

Vital signs
Low blood pressure, rapid pulse (may indicate dehydration, blood loss, risk of falls)

Oral cavity
Ecchymosis (may indicate forced oral sex), cigarette burns on the lips and fingertips, tooth fractures, ill-fitting dentures, oral venereal lesions

Ear, nose, and throat
Deviated nasal septum (from repeated trauma), finger imprints or rope marks around the throat

Eye
Subconjunctival or vitreous hemorrhage (may indicate new trauma), retinal detachment, orbital fractures, and traumatic cataracts (may indicate old trauma)

Skin
Burns, lacerations, ecchymosis, pressure ulcers, bruises in various stages of healing, lesions suggestive of use of restraints on the extremities, immersion burns (glove-stocking distribution)

Chest and abdomen
Rib fractures, pneumothorax, splenic rupture, and intra-abdominal hemorrhages (may be manifested as Cullen or Turner signs)

Nervous system
Focal findings on examination, impaired mental status, impaired function, depression, anxiety

Orthopedic
Impaired gait, leg length discrepancies due to fracture

ADAPTED FROM LACHS MS, PILLEMER K. ABUSE AND NEGLECT OF ELDERLY PERSONS. N ENGL J MED 1995; 332:437–442, AND MARSHALL CE, BENTON D, BRAZIER JM. ELDER ABUSE: USING CLINICAL TOOLS TO IDENTIFY CLUES OF MISTREATMENT. GERIATRICS 2000; 55(2):42–53.

Drawings and color photos are helpful in capturing legal evidence

tive, and administrative personnel, is helpful for eliciting information and devising a holistic intervention plan.[20,21]

Ensure safety, respect autonomy

After establishing the diagnosis of elder abuse, it is crucial for the physician to ensure the patient's safety while respecting his or her autonomy. Discuss the situation with the patient as soon as feasible and try to create a safety plan—specific actions to take if matters turn exceptionally violent and refuge is needed immediately.

On the other hand, paternalism and a tendency to "take over" can have dire consequences, including sequestration of the suspected victim by the abuser.

What if the patient refuses intervention?

One of the most difficult situations that can occur is when the diagnosis of elder abuse has been clearly established, but the victim refuses intervention.

In this situation, you should establish whether the patient is mentally capable of making this decision. Elders with decision-making capacity often refuse help because they are afraid of being institutionalized or mistreated further. If this is the case, the physician should tell the victim about the patterns, frequency, and recurrence of abuse and about resources and emergency shelters available, and develop and follow up on a feasible safety plan.[18]

For those who lack decision-making capacity, guardianship may be the next option. Often, state adult protective service agencies participate in this process, since by this time they have usually been involved in such cases as a result of mandatory reporting laws (**TABLE 4**).

Speed of intervention

Urgent. If you suspect a patient is in immediate danger and if the patient has decision-making capacity, encourage the patient to put physical distance between himself or herself

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TABLE 4

Tailored practical strategies for intervening in elder abuse

Situation / Strategies
Alzheimer patient with dementia-related disruptive behavior
Exclude underlying medical problems that may contribute to the agitation, eg, fecal impaction and infection
Refer for psychiatric evaluation, consider antipsychotic drugs
Use behavioral modification
Maintain continuity of care
Repeatedly reorient to place, person, time
Refer for home health services, respite care, possible nursing home placement
Caregiver to Alzheimer patient becoming physically assaultive during activities of daily living assistance
Arrange for respite services for the caregiver, contact support groups
Refer for counseling, home help services
Possible nursing home placement of the victim
Caregiving adult child with substance abuse problems using demented parent's money to feed own habits
Refer abuser to drug or alcohol rehabilitation and counseling
Guardianship to handle finances
Legal assistance
Decompensated schizophrenic adult child is assaultive to parents
Psychiatric referral for the abuser
Mental health counseling for the victim
Explore alternative living arrangements
Overt physical abuse by abusive child or spouse
Treat injuries
Refer to shelters
Give emergency contact phone numbers and addresses
Admit to the hospital to protect the victim
Contact adult protective services
Abused older adult without decisional capacity refuses intervention
Contact adult protective services
Arrange for guardianship, conservatorship
Provide assistance for financial management
Abused older adult with decisional capacity refuses intervention
Educate patient about incidence, risk factors, patterns, and consequences of abuse—abuse escalates with time
Give emergency contact phone numbers and addresses, information about shelters
Follow up

and the abuser. Options include hospitalization, transfer of care to a reliable friend or family member, or referral to an emergency shelter. If the home belongs to the victim, removing the abuser is of course the fairest strategy, although it may be difficult to implement.[18]

Less urgent. Tailor the intervention to the specific problem.[17] For example, if the care of the patient is burdensome because of multiple comorbid conditions and functional impairments, the following may be helpful for the victim:

- Home health services
- Adult day care
- Church activities and pastoral visitations
- Social service resources.

Likewise, the following may be considered for the caregiver:

- Periodic respite care
- Caregiver training
- Support groups
- Assistance from family or friends.

Also important to address are specific medical issues, such as pneumonia, congestive heart failure, incontinence, dementia, polypharmacy, psychiatric conditions such as anxiety and depression, and substance abuse by the caregiver.

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If these exist, order a home safety evaluation to ensure that the appropriate equipment is in the home. Consider moving the patient to an assisted living facility or a skilled nursing facility. Offer treatment for caregivers with substance abuse problems.

AN ETHICAL DILEMMA

The physician walks a tightrope, balancing confidentiality and trust with the need for patient safety. Many argue that mandatory reporting laws for elder abuse reflect paternalism and ageism.[18]

When there is an established trusting relationship between the physician and the patient, the physician can explain to the patient that it is the physician's obligation to report even suspected cases of abuse.

The goal is not to punish the victim or the abuser but to stop further abuse. Building a therapeutic alliance with the family may help. By not confronting the perpetrator and not blaming the victim, the doctor can assure the patient that safety is the desired outcome. When mistreatment results from the caregiver being overburdened, physician intervention may be welcome.

The intervening physician may use another physician or professional, friend, or family member whom the patient trusts to make recommendations.[18] Other sources of information about programs and services for the elderly are visiting nurses and personnel from adult protective services programs. A home visit to offer these services is also a way to gather information about the patient's safety.

CASE CONTINUED

Our patient Ms. T was assisted by collaborative efforts between the physician and the visiting nurse. The son agreed to let the visiting nurse service check up on his mother's health once a week. When the nurse warned him that she was obliged to report the probability of abuse in the home to the authorities, he consulted with the physician, and arrangements were made to include Ms. T in a house-call program. This case illustrates the importance of house calls in follow-up of cases of abuse. The visiting nurse service also remained involved in the case for some time.

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RESOURCES

State elder abuse hotlines. Toll-free, available 24 hours; consult local directory.

Adult Protective Services National Domestic Violence Hotline. 800-799-SAFE; TTY 800-787-3224.

National Center on Elder Abuse: http://www.elderabusecenter.org.

US Administration on Aging. http://www.aoa.gov.

ADDRESS: Mark Lachs, MD, MPH, Division of Geriatric Medicine and Gerontology, Weill Medical College of Cornell University, 525 East 68th Street, Box 39, New York, NY 10021; e-mail mslachs@mail.med.cornell.edu.

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