SAFE

Safe Accessible Forensic Interviewing for Elders

2-Day MDT Training

Participant Manual

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Acknowledgement

This training was produced by the Modell Consulting Group, LLC pursuant to a contract awarded by the Department of Justice's Elder Justice Initiative.

Purpose

This 2-day training is designed for multidisciplinary team members. It is the hope of all involved that after this training, professionals will feel better equipped to communicate with older adults who are victims of crime.

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INTRODUCTION

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"Elder abuse is not an easy problem to address: it can manifest itself in many ways—an older parent isolated and neglected by an adult child or caregiver; domestic violence by a partner (long-term or new), adult child or caregiver; sexual assault by a stranger, caregiver, or family member; abuse or neglect by a partner living with advancing dementia; financial exploitation by a stranger, trusted family member, or professional; or systemic neglect by a long-term care provider that hires too few staff members, provides insufficient training to its staff, and expends too few resources on resident care." (Connolly et al., 2014, p. 8)

Throughout the United States, the number of older adults is growing significantly. With this rise in the population, the frequency of older adults as victims of elder abuse requiring a criminal investigation is increasing.

Victims of elder abuse are highly heterogenous in terms of their medical and cognitive health; experience with trauma over their lifetimes; cultural, religious, spiritual, and social values; length of time in the United States; history of interactions with governmental agencies; language; and resilience.

Multidisciplinary team (MDT) joint investigations have been an established evidence-based model of successful investigations related to neglect and abuse of children. It has not been used for older adults nearly as much. The absence of the forensic interviewing model and joint investigation response for elder abuse victims leaves them at risk of not obtaining justice.

Trauma-Informed Approach

Trauma is an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening. Trauma often has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014).

Research indicates that up to 90% of older adults have experienced at least one traumatic event during their lifetime (Kuwert et al., 2013). These events include military combat; unexpected death of a partner, child, or someone close; severe injury or illness to themselves or someone in their life; or history of abuse or neglect. In addition, it is important for MDT members not to overlook the effects of trauma commonly experienced by older generations such as historical trauma, racial trauma, and trauma resulting from persecution (e.g., persecution of one's sexual orientation or gender identity; see "A Life Course Perspective on Older Adults" for more information on historical trauma, racial trauma, and trauma resulting from persecution). It is also important to recognize that the current victimization that is being investigated may be experienced as a traumatic event. This level of prevalence is why all MDT members must ensure that interviews and investigations are conducted utilizing a trauma-informed approach for older adults.

To accomplish this, MDTs must incorporate an approach based on their knowledge of trauma and the impact of trauma into the entire process. A trauma-informed approach involves understanding that trauma can always be present and requires a change in mindset from "what's wrong with you?" to "what happened to you?" This approach requires honing empathy and compassion skills while appreciating another individual's emotions with understanding and without judgment. Without these specialized skills, professionals risk reverting to the "what's wrong with you?" mindset and perhaps retraumatizing the older adult during the investigation (National Council on Behavioral Health, 2016).

MDT members must also understand the impact of trauma on memory. For example, memory components that may affect interviewing, such as free and cued recall, can be different for older adult survivors of post-traumatic stress disorder (PTSD; Golier et al., 2006). When asking questions, forensic interviewers are trained to create trauma-informed opportunities so the older adult can recount their experience in their own words, ask questions that minimize suggestibility, and work to minimize any possible negative impact on the older adult.

See additional information from the Centers for Disease Control and Prevention (CDC) and Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Center for Trauma-Informed Care (NCTIC) here: https://www.cdc.gov/cpr/infographics/00_docs/TRAINING_EMERGENCY_RESPONDERS_FINAL.pdf.

Strength-Based Perspective

The perspective that MDT members have during an investigation will have many effects when working with older adults who have experienced abuse. Historically, professionals across disciplines have adopted a deficit-based perspective that solely considers perceived risk factors and deficits of individuals, ignoring their rich and varied life experiences, skill sets, knowledge, and community resources. Older adults have lived through a lifetime of achievements, new opportunities, lifespan milestones, and difficult and traumatic events (Chapin et al., 2016). They have developed effective coping strategies and resilience. Ignoring an older adult's individual and environmental strengths may ultimately affect the dynamics throughout the investigation including the quality of information gathered. Therefore, conducting an effective investigation begins with a shift in perspective from a deficit-based perspective to a strengths-based perspective.

Adopting a strengths-based perspective requires a team member to focus on the older adult's positive traits and resiliency factors (Janssen et al., 2011). A strengths-based perspective values fostering trust and respect between MDT member and older adult in addition to reducing the inherent power differential, which is critical to developing rapport with individuals being served. When professionals focus on strengths rather than weaknesses in their questioning, it is more likely that the older adult is heard more completely, which will allow for a more successful investigation.

ELDER ABUSE DEFINITIONS

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Elder Abuse

Elder abuse is "a complex cluster of distinct but related phenomena involving health, legal, social service, financial, public safety, aging, disability, protective services, and victim services, aging services, policy, research, education, and human rights issues. It, therefore, requires a coordinated multidisciplinary, multi-agency, and multisystem response" (Connolly et al., 2014, p. 5).

There is no universal definition of elder abuse, and state and federal statutes use diverse definitions. Frameworks for the phenomenon have been developed for various purposes such as public health, benefits, eligibility for Adult Protective Services (APS) programs, and civil and criminal actions. Similarly, there is no single definition of *elder* or *older adult*.

Table 1. Definitions of Elder Abuse

Source	**Definition**
National Research Council	"Intentional actions that cause harm or create serious risk of harm, whether or not intended, to a vulnerable adult by a caregiver or other person who stands in a position of trust to the elder, or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm" (National Research Council, 2003, p. 1).
CDC	"Elder abuse is an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult" (CDC, 2020, para. 1).
United States Department of Justice (DOJ) Roadmap Project	"Physical, sexual or psychological abuse, as well as neglect, abandonment and financial exploitation of an older person by another person or entity that occurs in any setting (e.g., home, community or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability" (Connelly et al.,2014, Appendix A, p. 2).
World Health Organization	"A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (World Health Organization, n.d., para. 1).

Source	Definition
Elder Abuse Prevention and Protection Act of 2017 (Public Law 115–70)	"Includes abuse, neglect, and exploitation of an elder"; this is further defined in Section 2011 of the Social Security Act (42 U.S.C. 1397j: **Abuse:** "The knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm." **Caregiver:** "An individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting." **Exploitation:** "The fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets." **Elder:** "An individual age 60 or older." **Neglect:** "The failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or self-neglect."

These definitions of elder abuse that describe both criminal and non-criminal acts, provide a way to frame and distinguish elder abuse from other acts (criminal or non-criminal) committed by and against older adults (e.g., self-neglect, stranger crimes, and many scams and frauds). This framework excludes some of these kinds of cases that are investigated by APS or eligible for protective court proceedings, such as guardianship.

Just as there is no single definition of elder abuse, there is no single accepted age when a person becomes an elder. For example, both the Elder Abuse Prevention and Prosecution Act of 2017 and Older Americans Act of 1965 (42 USC §3002(38)) define an older adult as 60 years of age or older. The DOJ, Office on Violence Against Women's Enhanced Training and Services to End Abuse in Later Life Program, defines its target population as persons age 50 and above. Many tribal communities define an elder as 50 or 55 or older. Social Security and Medicare programs use the age of 65. Some states do not use an age definition at all but include all adults (age 18 and older) who have a physical, developmental, or intellectual disability that makes them unable to meet their basic needs or protect their legal rights.

Proof in Elder Abuse Cases

Depending on the jurisdiction, responding system, and agency, various laws and regulations will guide how elder abuse is reported and handled and will establish the applicable standard of evidence or burden of proof required for civil and criminal proceedings. For example, some states and tribes have specific elder abuse or vulnerable adult abuse criminal laws, while others rely on common law and statutory crimes to hold offenders accountable. Such criminal actions are usually subject to the legal standard of guilt beyond a reasonable doubt.

Every state (except New York), the District of Columbia, and the territories and possessions of the U.S. have enacted elder or vulnerable adult abuse reporting statutes (APS Reporting Statutes) that mandate certain professionals or all persons to report suspected abuse to an identified protective services or criminal justice agency. The standard to report is usually "reasonable suspicion."

Allegations meeting eligibility criteria (which differ from jurisdiction to jurisdiction) are investigated, usually by a protective services agency, to evaluate risks and offer services and interventions to reduce risks and protect clients. The standard of proof for founding an allegation is typically preponderance of the evidence. If cases require civil interventions such as guardianship or a restraining order, the legal standard is preponderance or clear and convincing evidence, depending on local laws. These standards are defined in the next section.

Forms of Elder Abuse

MDT members should work with their team or community partners to become familiar with local statutes to see which forms of abuse may be included in their jurisdictions, including criminal and civil statutes, reporting laws, and eligibility for APS assistance (these statutes can be found at Elder Justice Statutes). Elder abuse typically encompasses several forms of conduct, which are defined in different ways across jurisdictions. Not all instances of elder abuse rise to the level of a crime.

These definitions of types of elder abuse come from The National Center on Elder Abuse:

Physical: "Intentional use of physical force that results in illness, injury, pain or functional impairment"

Physical abuse may include over- or under-medicating an older adult to make them compliant, confused, less able to recognize or report, or keep them quiet; forced feeding; and improper use of chemical and other restraints. It also includes domestic violence and abuse in later life and strangulation and suffocation committed against older adults. These actions may be undetected and result in death when the victim would have survived the assault in earlier life.

Sexual: "Non-consensual sexual contact of any kind"

Sexual abuse includes acts committed upon a person unable to give legal consent to sexual contact. It includes the following:

- Hands-on conduct (e.g., various sex crimes, forced production of pornography)
- Hands-off conduct (e.g., forced watching of pornography or sex acts)

- Harmful genital practices (e.g., painful, intrusive, and unnecessary cleaning; inspection or handling for the perpetrator's sexual gratification; Ramsey-Klawsnik, 1996).

Older victims who are sexually abused by family members often are people living with dementia and are dependent on others for care and the management of their assets. Sexual abuse may also be part of a pattern of complex, multifaceted, intimate partner abuse (Ramsey-Klawsnik, 2003).

Neglect by a caregiver: "Caregivers or other responsible parties failing to provide food, shelter, health care, or protection"

Neglect is the failure to act by one with a duty to act (duty of care) on behalf of a person unable to provide for their own needs or to protect their legal rights. While there are variations regarding the relationships that give rise to a legal duty of care across jurisdictions, a person can be a caregiver because they are paid to provide care (contractual relationship), because of a legal relationship such as a spouse or guardian, or because they have assumed care and are not free to simply abandon the care recipient.

Victims of neglect often have significant physical and mental impairments and are dependent on others for care. Many neglected older adults are unable to describe their victimization and, because of their condition, may be easily isolated so that the conduct is not detected.

A caregiver may provide personal care or have the duty to arrange for and compensate caregivers. Such a duty may arise through a power of attorney, guardianship, contract, or other agreement.
Abandonment: Some jurisdictions include additional forms of abuse to their laws, such as abandonment. Abandonment is the desertion of an elderly person by an individual who has assumed responsibility for providing care for an older person or by a person with physical custody of the older person (National Center on Elder Abuse, n.d.). In jurisdictions that do not include abandonment, the conduct is usually included in other forms, such as neglect.

Financial: "Misappropriation of an older person's money or property"

Financial exploitation includes the illegal or improper use of an elder's funds, property, or assets. These are some examples:

- Taking or selling things without permission
- Making older adults sign legal documents they do not understand
- Forcing an older adult to give away something that belongs to them
- Impersonating the older adult to obtain goods or money
- Keeping money that belongs to the older person, stopping the older person from using their own money
- Keeping information about the person's assets from the older person (DOJ, Elder Justice Initiative, n.d.)

Some—but not all—victims have physical and cognitive deficits that interfere with their ability to understand financial transactions or pay bills.

Financial exploitation is sometimes divided into two categories: financial abuse and elder fraud. "Exploitation may also involve coercion, enticement, intimidation, and/or undue influence for one's own profit or benefit. As distinct from fraud, financial abuse involves a breach of trust between a vulnerable older person and a family member, close friend, caregiver, or person in a position of trust who misuses the elder's funds to serve his or her own needs at the elder's expense" (Deliema & Conrad, 2017, p. 141). In elder fraud cases, scams are committed by perpetrators not personally known to their victims (Deane, 2018; Deliema & Conrad, 2017).

Scams: Perpetrators have several ways of encountering and engaging with their victims. Some meet their victim through face-to-face engagement, online, via telephone, or through the mail. The majority of scams that specifically target older adults focus on the following:

- Financial gain for the older adult (e.g., lottery scams)
- A desire for an intimate relationship (e.g., romance scams)
- Providing help (e.g., grandchild scam)
- Compliance with authority (e.g., warrant out for arrest scam)
- Fear of loss of benefits or safety (e.g., social security scam)

The MDT should be aware that these scams are constantly evolving. The names of scams are not as important to the MDT as an understanding of how they occur. The use of the name of a specific scam with an older adult during an interview is often irrelevant. The MDT should understand that in each of these scams, the perpetrator has convinced the older adult to trust that they have the victim's best interest in mind. Perpetrators may say, "if you send money, I can keep you from being arrested" or "if you send money, I can come to visit you, and we can spend time together." Perpetrators build and then exploit that trust in almost all forms of scams.

While many of these scam types target older adults, being a victim of the scam does not indicate a cognitive deficit, a lack of intelligence, or a victim's weakness. Instead, it is possible that the older adult may not want to believe they are the target of fraud or may not share possible fraud with their family members due to feelings of embarrassment and guilt. A strengths-based approach to the interview is critical to support the older adult who may be embarrassed or ashamed that they were the victim of a scam. (More information can be found about scams in Appendix IV.)

Emotional/Psychological: "Inflicting mental pain, anguish, or distress on a person"

Emotional abuse is accomplished through verbal and nonverbal acts, many demeaning or degrading of the victim.

Examples include these:

- Stalking in later life
- Bullying
- Vandalism of the victim's prized possessions
- Refusing to talk to an older adult
- Infantilizing an older person
- Isolation
- Threatening abuse of a pet/abuse of a pet

Emotional/psychological abuse, such as threats to place an older adult in a nursing home, can be used to dissuade or prevent the reporting of physical abuse or financial exploitation or to facilitate other forms of abuse (See "Multiple Victimization Events/Polyvictimization").

Multiple Victimization Events/Polyvictimization

Some perpetrators engage in a single form of abuse, though individual acts may recur (i.e., multiple victimization events or multivictimization). Sometimes, multiple forms of abuse co-occur. Called polyvictimization, it is defined in the elder abuse framework as follows: "when a person aged 60+ is harmed through multiple co-occurring or sequential types of elder abuse by one or more perpetrators, or when an older adult experiences one type of abuse perpetrated by multiple others with whom the older adult has a personal, professional or care recipient relationship in which there is a societal expectation of trust" (Ramsey-Klawsnik et al.,2014, p. 15).

U.S. studies have estimated that 30% to 40% of older abuse victims reported to APS experience multiple forms of victimization by the same offender. In one study, 34% of investigated APS reports involved financial exploitation, accompanied by either neglect or physical abuse. A study of APS cases in

Cleveland found that polyvictimization occurred in 89.7% of cases in which psychological abuse or neglect occurred (Ramsey-Klawsnik, 2017).

Rates of polyvictimization among persons living with dementia are significant. One study of 129 community-dwelling persons living with dementia and their caregivers found that elder abuse occurred in nearly half of the cases, with more than one form of abuse committed in 31% of the cases. All physical abuse victims were also psychologically abused, neglected, or both (Wiglesworth et al., 2010).

MDT members should always be aware that polyvictimization can happen in any setting. One study that assessed polyvictimization in both community-based and long-term care settings found that 15% of the older adults residing in a long-term care facility experienced two or more forms of elder abuse simultaneously. Residents who needed assistance with a larger number of activities of daily living (ADLs) were at greater risk of being abused in multiple ways. If a resident had been financially exploited, their risk for physical abuse, emotional abuse, and neglect increased substantially (Post et al., 2010). Another study reviewed allegations of sexual abuse allegedly committed against residents living in facilities: 45% reported they had been sexually assaulted, 13% had been threatened by their abusers, and 19% had been victims of other forms of abuse (Ramsey-Klawsnik et al., 2010). Sometimes, as a result of abuse and neglect by another or other circumstances, an older person may become unable or unwilling to provide themselves with adequate necessities and resources for maintaining safety and independence (Dyer et al., 2007). It can take the form of physical, medical, and/or mental health neglect (Burnett et al., 2014).

Settings in Which Elder Abuse Occurs

Most older adults live in their homes in the community. Only about 1.5 million adults (or about 3.4% of people age 65 and older) live in long-term care facilities such as nursing homes. Most abuse occurs in community (home) settings rather than institutional settings (Acierno et al., 2010; Kosberg & Nahmiash, 1996; Rosay & Mulford, 2017), which is not surprising given that most older adults reside in community settings. Some 89.3% of reports to APS programs across the United States occur in domestic settings (Teaster et al., 2006).

Abuse in Long Term Care Settings

Because elder abuse can occur in any setting, it is useful for MDT members to recognize that the response system for abuse occurring in long-term care settings differs from that of elder abuse committed against community-dwelling older adults (Daly, 2017). State regulation of long-term care facilities imposed by federal regulation results in a different response system. Resident abuse is within the jurisdiction of the state's survey and certification entity (with federal oversight) and the Medicaid Fraud Control Units, which are federally funded but state entities typically housed in the state's Office of the Attorney General. The Long-Term Care Ombudsmen program provides advocacy for residents but does not conduct investigations. Further, only approximately half of APS programs have jurisdiction in long-term care settings.

There is increasing awareness of the forms that elder abuse takes in long-term care settings. These include "seclusion, withholding medication, over medicating resident to resident aggression, under-treating pain, chemical or physical restraint, poor hygiene, skin lesions, dehydration, malnutrition, pressure ulcers, urine burns and excoriation, contractures, delirium, vermin infestation, and accelerated functional decline" (Daly, 2017, p. 70). The risk of elder abuse is increased for residents without family, friends, or advocates; those living on public assistance; and those who are aggressive (Brandl et al., 2007).

Institutional factors also increase the risk for abuse and neglect of residents in long-term care settings include the following:

- Stressful working conditions due to staffing shortages and other factors (understaffing in nursing homes results in neglect of residents and a 22% increase in hospitalizations; CMS, 2001)
- Staff burnout
- The combination of residents' aggressive behaviors with inadequate staff training on managing problematic behaviors (Hawes, 1989)
- Poor hiring and staff screening
- Lack of management oversight and supervision

Resident-to-Resident Aggression

Another form of abuse in long-term care settings is resident-to-resident aggression (RRA), defined as "negative and aggressive physical, sexual, or verbal interactions between long-term care residents that in a community setting would be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient" (Rosen et al., 2008). RRA is underreported but appears to be common (U.S. Government Accountability Office, 2002). According to the National Center on Elder Abuse (2013), RRA reports are the second most commonly reported type of abuse in long-term care facilities, accounting for 22% of all reports.

Key Concepts: Competency, Capacity, and Consent

Key to any discussion of elder abuse are the concepts of competency, capacity, and consent. MDT members should be generally aware of these concepts because they may arise in pre-and post-interview meetings. They may be raised as reasons not to interview at all or when evaluating whether an older person provided credible information during the interview.

Competency

Competency and capacity are often used interchangeably, but they are separate and distinct concepts. Competency is a legal determination made by a court pertaining to whether someone is able to do certain things. The public is most familiar with competency to stand trial. For our purposes, however, testimonial competency is most relevant—whether a witness can give testimony.

All adults are presumed competent to testify unless and until a court determines otherwise. The legal standard is quite low—can a witness understand the duty to be truthful and communicate information so as to be understood? "Witness (including the victim) competency to testify requires a minimal ability to observe, recollect, and communicate information and understand the duty to tell the truth" (Aequitas, 2017, p. 16).

In a legal context, the determination of competency is all or nothing; a person cannot be almost competent—the person either is or is not competent at the time a court makes its ruling. Because the determination is time-specific, a person can be found incompetent today but be deemed competent on another day.

Capacity

In contrast, capacity is a clinical term describing a person's physical and/or cognitive abilities (Falk & Hoffman, 2014). It focuses on a person's functional abilities (such as to drive, manage their finances, and perform ADLs). Capacity may vary by the complexity of the act or decision, time of day, medications, illness, fatigue, trauma, and grief. Capacity is not all or nothing; rather, it is task-specific, so a person may have certain capacities while lacking others.

Capacity is contextual and varies by the complexity of the task to be done or the decision to be made. The more significant the decision and the consequences of the decision, the higher the level of capacity required. "A person may have deficits relating to functional capacity, but still be competent to testify. A person may have certain functional capacities but be found legally incompetent to testify or stand trial" (Aequitas, 2017, p. 16).

Similarly, a person can have functional deficits (vision, mobility) but be able to report accurately and fully participate in an interview about what has occurred. The MDT may need to modify the interview process by making changes to the interview setting, changing the interview location, providing sound amplification, and otherwise accommodating the functional needs of the older adult.

Capacity encompasses a broad range of concepts, but two particular types of capacity are decision-making capacity, which includes both the ability to make a decision, and executional capacity, which is the ability to implement a decision.

Decision-making (also called decisional) capacity at the time of a critical transaction or event is the most common legal issue in elder abuse cases. A person's decision-making capacity to make a gift, execute a will, manage their financial affairs, accept or refuse medical treatment or services offered by APS, drive, marry, or enter into a contract may all be challenged.

All adults are presumed to have decision-making capacity unless and until it can be demonstrated otherwise. Decision-making capacity is determined by a person's ability to do the following:

- Understand the basic facts about a decision
- Appreciate how the decision relates to their personal situation, including their strengths and limitations
- Be able to reason and rationally evaluate information by comparing options and the consequences of alternative choices
- Be able to make an informed decision

Executional capacity requires that a person is able to do these things:

- Formulate a plan
- Make changes in response to novel or changing conditions
- Delegate tasks to appropriate others when personally unable to implement the plan (Falk & Hoffman, 2014; Naik et al., 2008)

Financial Decisional Capacity

Given the extent of financial exploitation, cases often involve a person's financial decision-making capacity. This form of capacity is defined as "the capacity to manage money and financial assets in ways that meet a person's needs, and which are consistent with his or her values and self-interest" (Marson et al., 2011). It includes financial literacy and requires executive function.

Financial capacity can decline in later life and may present as increasingly rash and irrational financial decision making and may be a sign of mild cognitive impairment (MCI) or impending Alzheimer's disease (Marson & Sabatino, 2012). Declines in financial capacity can weaken a person's financial judgment and reduce their ability to understand the consequences of financial decisions, protect themselves from exploitation, or recognize their victimization (Deane, 2018). Declines in financial capacity or executive functioning should not be viewed as indicators that an older adult cannot provide reliable information during a forensic interview.

Executive function is the foundation for judgment and is essential for making complex financial decisions. It includes the ability to plan; organize, sequence, and process information; and regulate mood and affect. A person can have deficits in executive function without having dementia or memory impairment (Dyer et al., 2007; Institute of Medicine, 2015).

Consent

Consent is the most common defense in financial and sexual abuse cases and is often raised in caregiver neglect situations. Defense will often argue that the older adult consented to giving money to the offender or to the alleged sex act or refused offers to seek medical treatment.

Consent requires these components:

- The person who allegedly gave consent must have the decision-making capacity to make the decision and give consent as alleged (e.g., whether the older adult had the decisional capacity to deed his home to another, enter into a contract, or make a large gift).
- The person who allegedly gave consent must understand the true nature of the transaction (what they are consenting to) so they were not misled or deceived about or denied critical information.
- The person who allegedly gave consent did so freely and voluntarily without duress, threats, manipulation, or undue influence.

Even when a person with decision-making capacity seems to have consented, consideration should be given as to whether the consent was obtained through the use of undue influence. If the older adult did not have full knowledge of the true nature of what they agreed to or agreed because they were manipulated, threatened, or forced, they have not given legal consent. MDT members should consider asking questions about conversations to screen for fraud, coercion, misrepresentation, or manipulation because these, too, vitiate consent. See "Undue Influence" for additional information on this topic.

Consent is intertwined with capacity: a person cannot give legal consent if they lack **adequate** decision-making capacity. Like capacity, consent is also fluid and may change from day to day and moment to moment, depending on the individual and their circumstances.

HISTORY OF ELDER ABUSE

HISTORY OF ELDER ABUSE

In the United States, attention to addressing the needs of older adults vulnerable to abuse and neglect can be traced back to the 1960s. The White House Conference on Aging in 1961 recommended a multidisciplinary effort to protect vulnerable older adults (NAPSA-Now.org, 2021). In 1962, amendments to the Social Security Act authorized funding to states to develop protective services units. Additionally, throughout the 1960s, the Administration on Aging funded several projects that provided protective services to older adults.

APS offered a social service approach to addressing abuse and neglect that remains in place today. Initially, protective services focused primarily on supporting individuals in situations of neglect through social service and civil legal remedies (Anetzberger & Thurston, 2021).

In the 1970s, attention to older adults' vulnerability took the next step from a primary focus on neglect to include physical abuse due to the first significant national press about elder abuse and federal legislative public hearings (Teaster et al., 2010). The terms "granny bashing" and "granny battering" started in the U.K. in 1975 and were used in the United States after these press articles and hearings. This conceptualization of abuse focused social service interventions on the physical assault of older adults, particularly older adult women, by family members in caregiving situations.

In contrast to child abuse interventions that included law enforcement as part of the solution, elder abuse interventions during the 1970s and 1980s remained focused almost exclusively on social service interventions. Even with the introduction of physical abuse, the theory was that family caregivers were abusers because of the natural stress of caregiving. This premise of why the abuse occurred directed social service interventions that could decrease stress to prevent abuse and did not include law enforcement intervention that would punish the overburdened caregiver.

"Research in the 1980s and 1990s concluded that while abuse *may* be the result of caregiver stress, it is often due to 'abuser psychopathology'" (McNeal

& Brown, 2019, p. 100). As a result, interventions began to be based on domestic violence models, with more criminal justice system involvement (McNeal & Brown, 2019).

By the end of the 1980s, the concept of victimization of older adults began to evolve even further. In 1987, amendments to the Older Americans Act expanded the definition of elder abuse beyond neglect and physical abuse to include sexual abuse, emotional/psychological abuse, abandonment, and financial exploitation (Teaster et al., 2010). Despite this broad definition, abuse and neglect in caregiving situations continued to be the primary focus of protective services units during the 1990s, too often not involving law enforcement. Neglect cases, especially self-neglect cases, often required intensive and expensive social service interventions, leaving little funding for other aspects of elder abuse.

During the 1990s, there was an emerging trend to include a criminal justice framework for elder abuse (Connolly, 1997). Research had questioned the caregiver stress model as an explanation for abuse. All caregiving is stressful, and most caregivers successfully provide care without abusing the older adult. The focus of why abuse occurs started to look at the characteristics of the abuser that led to the violence, which was more closely aligned with a family violence model.

While national legislation was scant in supporting criminal justice interventions, more and more local jurisdictions started viewing elder abuse with a criminal justice approach. During this time, many states passed laws that criminalized the abuse and neglect of older adults and allowed for sentence enhancements for perpetrators if the victim was an older adult or a person with a disability.

In the early 2000s, elder abuse interventions started to be thought of as part of a framework of elder justice. In 2002, the Elder Justice Act was introduced. This act represented the first significant piece of legislation that added the concept of criminal justice to the spectrum of elder abuse interventions. In the executive summary for the act, Senator Breaux, the primary author of the bill,

defined elder justice as "assuring that adequate public–private infrastructure and resources exist to prevent, detect, treat, understand, intervene in and, where appropriate, prosecute elder abuse, neglect, and exploitation. From an individual perspective, elder justice is the right of every older American to be free of abuse, neglect, and exploitation" (Elder Justice Act, 2002).

The Elder Justice Act was passed 8 years later in 2010 as part of the Patient Protection and Affordability Act. However, the enacted version still focused primarily on public health and social services approaches to elder abuse (Congressional Research Services, 2020). It did not include the criminal justice responses to elder abuse contained in previous versions.

Throughout the 2000s to today, forensic techniques have become one of the approaches to elder abuse in some states and communities. Multidisciplinary fatality review and case review teams coordinate local responses between the social service and criminal justice systems to address gaps in responding to and preventing elder abuse in many jurisdictions (Taylor & Mulford, 2015). States continue to enact statutes criminalizing elder abuse, and in some cases, requiring training of law enforcement who respond to elder abuse.

In 2017 the Elder Abuse Prevention and Prosecution Act became the first significant piece of federal legislation to embrace the forensic issues involved in addressing abuse (DOJ, 2020). This legislation focuses on the need for data, calling on several federal agencies to work together to better understand both the protective services and criminal elements of elder abuse. Notably, it assigned specific requirements to the DOJ to investigate and prosecute elder abuse crimes and to provide or make available training and resources for state elder justice professionals.

Today, elder abuse prevention and response work continue with new legislation being considered at the federal and state levels. Local jurisdictions continue to put together multidisciplinary task forces to address elder abuse in their communities. Law enforcement and APS are working together to develop best practices to pursue both civil and criminal remedies, when appropriate, to provide justice for older adult victims.

STATISTICS AND INCIDENT RATES

STATISTICS AND INCIDENT RATES

Elder abuse is a problem that is only beginning to be understood. With the Elder Justice Act and Elder Abuse Prevention and Protection Act, there is a commitment to gain a better national understanding of the issue similar to what is learned from the data collected for child abuse. The following statistics are a snapshot of what is currently known about some critical components of elder victimization.

An aging U.S. population means there is a need for increased responses to victimization (Administration for Community Living, 2020).

- In 2019, more than one in every seven people (54.1 million) in the United States was 65 years of age or older, and is estimated to reach 94.7 million in 2060.
- In 2019, 24% of those age 65 and older were members of a racial or ethnic minority population, with a projection of reaching 34% by 2040.
- In 2019, there were more older women (30 million) than older men (24.1 million).
- In 2019, nearly 10% of older adults lived below the poverty level.
- The 85 years and older population is projected to increase from 6.6 million in 2019 to 14.4 million in 2040.

Elder abuse is prevalent worldwide (World Health Organization, 2021).

- A 2017 study, based on 52 studies in 28 countries, estimated that 15.7% of people aged 60 years and older were subjected to some form of abuse over the past year.
- The breakdown of abuse by type finds psychological abuse to be the most reported at 11.6%, followed by financial abuse at 6.8% and neglect at 4.2%. Physical abuse and sexual abuse are the least reported at 2.6% and 0.9%, respectively.

Financial fraud/exploitation and neglect are the most common types of abuse in the United States (Acierno et al., 2010)

- Financial exploitation by a family member affects 5.2% of older adults, and neglect affects 5.1% of older adults in the United States.
- Psychological abuse is third at 4.6%.
- Physical abuse and sexual abuse account for a much smaller percentage, 1.6%, and .6%, respectively.

Elder abuse is significantly under-reported in the United States (New York State Elder Abuse Prevalence Study, 2011).

- The New York State Elder Abuse Prevalence Study found 24 unreported cases of abuse for every reported case.
- The same report found:
    - Neglect (1:57)
    - Financial (1:44)
    - Physical/Sexual (1:20)
    - Emotional (1:12)

Abuse and neglect are occurring against older adults in long-term care at alarming rates (National Center on Elder Abuse, 2021).

- In a study of nursing home residents, 44% reported having been abused, and 95% reported having been neglected or seeing another resident neglected.
- In a nursing home staff study, more than 50% of nursing home staff admitted to mistreating older residents within the last year, including physical violence, mental abuse, and neglect.

IMPACT OF ELDER ABUSE

IMPACT OF ELDER ABUSE

Like other aspects of elder abuse, we are only beginning to understand the impact abuse, neglect, and exploitation have on victims' lives. The victimization experience can have devastating physical, psychological, social, and financial effects on older adults.

Physical Health Impact

The acts of abuse can lead to immediate impacts on physical health (National Center on Elder Abuse, 2021). Physical abuse can cause injuries, including abrasions, lacerations, bruises, burns, fractures, head injuries, and internal organ damage. Neglect can cause physical health issues, such as skin breakdown, infections, and debilitation. Sexual assault often has similar injuries associated with physical abuse and includes additional health issues such as sexually transmitted diseases, urinary tract infections, and irritation or pain of the anus or genitals.

Some effects occur months and years after the abuse occurred. Less immediate physical health issues include general physical malaise, bone or joint problems, digestive problems, chronic pain, high blood pressure, or heart problems.

Any physical health impact can be incredibly detrimental to older adults because of slower recovery rates due to the natural aging body and sometimes preexisting medical issues (Podnieks, 2017). Even minor physical injuries can require older adults to seek medical care to prevent or address the potential of severe disabilities or death. Numerous studies have demonstrated a connection between abuse and the need for emergency department usage, hospitalization, hospice care, and nursing home placement. This association has been shown for physical abuse, sexual abuse, neglect, and even financial exploitation.

Older adults who are victims of polyvictimization experience multiple harms, including increased hospitalization (Dong & Simon, 2013), physical injury, psychosocial injury including depression and PTSD, financial loss, loss of home, and placement in a long-term care facility (Ramsey-Klaswsnik, 2017).

Abuse can also result in death. Studies have demonstrated that victims of abuse and neglect are at risk of early death up to three times higher than older adults who are not victims (Dong et al., 2009; Lachs et al., 1998; Yunus et al., 2017). A study that specifically looked at death rates within 5 years by category of abuse found that caregiver neglect was the number one type of abuse associated with early death; financial exploitation was second. Regardless of the kind of abuse, the threat of premature death is real (Burnett, et al., 2016).

Implications for the MDT

Older adults who have experienced physical abuse may have physical conditions or needs that require accommodations during the investigation. For instance, medication may hinder the person's ability to focus, so identifying an older adult's most alert time of the day may be a consideration. Assistive devices (wheelchair, walker, etc.) may be needed for the older adult to ambulate, in which case spaces where you may interact with the older adult (e.g., the interview space) must be able to accommodate the device. Certain physical conditions may impede a person's ability to sit for prolonged periods of time or necessitate frequent changes in body position. These needs and the appropriate solutions should be determined prior to meeting with the older adult when possible (see "Pre-Interview Considerations" for more information on potential required accommodations).

Psychological Health Impact

While physical health consequences to victimization are more easily identified and assessed, the impact on psychological health is often missed and unaddressed (Dong et al., 2013). Studies on the psychological effects of abuse have identified higher rates of depression, generalized anxiety disorder, PTSD, and poor self-reported health (Acierno, 2019; Dong et al., 2013).

Social support is a crucial factor for older adults in dealing with the psychological effects of abuse. In a key study, strong social support diminished the impact of elder abuse for depression and eliminated it for generalized anxiety disorder and self-reported poor health (Acierno, 2019).

The psychological effects of abuse are not limited to physical abuse, neglect, and sexual abuse. The effects from financial abuse occur at similar rates to the other forms of abuse (Acierno, 2019).

Social Impact

As a result of various forms of elder abuse, social relationships are impacted—families may be torn apart, and friends may stop visiting.

Implications for the MDT
Older adults who have been isolated from family and friends may exhibit a higher degree of dependency on the offender and demonstrate a reluctance to report acts of abuse. Further, they may minimize what occurred or blame themselves for the abuse. (See "Elder Abuse Dynamics" for more information regarding the social impact of elder abuse.)

Financial Impact

While the exact costs are not known, expenses associated with elder abuse that impact the victim, family members, and the community are in the many billions annually (Connolly et al., 2014). Costs include health and medical expenses; costs to community services, justice systems, institutional settings, and care expenses; and labor costs (Spencer, 2000).

Many adverse events in long-term care facilities result from neglect and abuse related to inadequate treatment, care, and staffing. These impacts of elder abuse cost the government—and ultimately the taxpayers who fund Medicare and Medicaid—some $2.8 billion each year in Medicare hospital

costs and additional significant Medicaid costs (Office of Inspector General, 2014).

Financial exploitation results in tremendous losses to older adults. A recent study concluded that older adults lose $36.48 billion annually to financial abuse (True Link, 2015). These losses include the following:

- $16.99 billion to financial exploitation (defined as instances in which misleading or confusing language is used, often with social pressure and tactics to take advantage of cognitive decline and memory loss)
- $12.76 billion to identity theft and scams
- $6.67 billion to deceit or theft by someone in a trusting relationship with the older adult

BIASES AND ASSUMPTIONS ABOUT AGING

BIASES AND ASSUMPTIONS ABOUT AGING

Class Activity: Bias and Assumptions Part 1 **Scenario:** Jenny is the reported victim of domestic violence. The police report indicates the argument began when she accused her husband, Marty, of having an affair. Jenny reports that Marty said she was "crazy", and he became angry. Marty tried to embrace her; she pushed him away and told him to stay away from her. Marty came toward Jenny in an aggressive manner, pushed her backwards into a wall and then began to strangle her. She reports that she saw stars and then things went dark. The next thing she knew she was lying on the floor.
What is your initial reaction to this scenario?

Class Activity: Bias and Assumptions Part 2

Scenario:

You have been asked to conduct an interview with Jenny, she tells you that her brain feels like scrambled eggs and her mind is a blank, she is 25.

1. **How would you feel if the same situation happened to an older adult?**

2. **How would you feel if the alleged offender was the child of the victim, or a caretaker?**

Ageism

The World Health Organization defines ageism as "the stereotyping and discrimination against individuals or groups on the basis of their age." Ageism is one of the most pervasive yet unrecognized types of bias and prejudice in society. It is associated with "poor cognitive, functional, and mental health outcomes, employment harassment and discrimination, financial harms, and social marginalization" (National Center on Elder Abuse, n.d., p. 1). MDT members must be aware of how ageism can play out during an investigation. For the most part, MDT members don't mean to act in an ageist way. Still, the negative stereotypes that have dominated societal views about older adults and aging can easily influence forensic interviews.

Common Stereotypes of Aging

Everyone is inundated with messages about aging and what it means to get older. Some of these messages have been positive (e.g., caring grandparent, wise, wealthy, receiving government benefits, honest), but unfortunately, negative stereotypes are often predominant (Richardson & Shelton, 2006). Here are some common negative stereotypes of older adults:

- All older adults will get dementia.
- Older adults are not sexually active.
- Older adults are set in their ways.
- Older adults are not capable of learning new information.
- Intelligence declines in old age.
- Most people end up in a nursing home.
- Older adults all act alike.
- Older adults grow increasingly irritable and angry as they age.
- Older adults are not tech-savvy.

Although none of these are accurate or evidence-based, all of these negative stereotypes are common perceptions of younger adults about older adults.

Addressing Stereotypes and Ageism in Multidisciplinary Teams

Negative stereotypes can influence professional behavior. For example, research has found that younger adults often change their speech patterns when talking with an older adult (Corwin, 2018). Even when the person is cognitively sharp and socially alert, younger adults may switch to a condescending and patronizing language pattern or begin to speak loudly and slowly.

Acting on stereotypes can create numerous barriers to an effective interview, including humiliation, embarrassment, shame, disinterest, anger, fear, and distrust. Critical to combatting negative stereotyping and ageism for MDT members is the use of a strengths-based perspective. In reality, older adults are heterogeneous, and many are resilient having developed strong coping skills from decades in which they accomplished achievements, dealt with life changes, overcame adverse events, and survived trauma. When appropriate, asking how an older adult dealt with a past life experience may support a victim in responding to the current situation.

As noted earlier, when MDT members consider an older adult's set of strengths rather than weaknesses, MDT members are more likely to ensure that older adult voices are heard and will allow the investigation to follow best practices. This approach does not mean that MDT members should ignore challenges or barriers presented by the older adult witness; instead, the MDT should focus on their strengths in order to obtain accurate and reliable testimony (Love, 2015, 2019).

To do this, MDT members should approach every investigation with an open mind. Even when MDT members believe they have a lot of experience and expertise in working with older adults, they can always learn and grow with each new interview. All MDT members need to honestly self-examine their own beliefs, attitudes, assumptions, thoughts, and words regardless of their level of experience. By doing this, MDT members can convert stereotypes into a strengths-based approach (see also "Strength Based Perspective").

OLDER ADULTS AND ABUSE DYNAMICS

OLDER ADULTS AND ABUSE DYNAMICS

A Life Course Perspective on Older Adults

There are more older adults living today than ever before. Older adults as a category may include people across four or more decades, from age to well past 100. Their experiences will differ depending on their age, culture, race, ethnicity, health, and other factors.

The category of older adults comprises three cohorts: the young-old, aged 60 to 74; the old, aged 75 to 84; and the old-old, aged 85 and older. When thought of in this way, the diversity of older adults becomes more evident. Some older adults experienced World War II as children or young adults, the Holocaust, and the Great Depression. Other older adults fled to the U.S. as refugees when they were children, came as adults after helping the U.S. government in various foreign military operations, or arrived as the aging parents of long-settled immigrants. Some came for economic opportunities; others fled oppression, genocide, and gang warfare.

In the United States, some older adults who identify as LGBTQ+ have lived through a social and sexual revolution. Many were closeted for decades, unable to live openly, marry their partners, adopt children, or openly serve in the military. Many were ostracized by their families. Laws criminalized consensual conduct, and some professions denied them. As they aged, many people in the LGBTQ+ community could not visit their spouses and partners in hospitals and long-term care facilities, could not file joint income tax returns, and could be fired for who they are.

Some older adults of have faced discrimination and economic, health, and job disparities based on their skin color and appearance across their lifespan. Many have been targeted for race-based violence and mistreatment, and institutions and entities that were supposed to protect them have histories of unfair treatment. Some have been required to use separate accommodations, and some have been denied equal education, opportunity, and voting rights and otherwise denied the same rights and opportunities as Whites.

Some American Indian and Alaska Native older adults lived through forced removal from homes and communities to boarding schools where they were forbidden to practice rituals, speak their native languages, or wear traditional clothing. Some women were forcibly sterilized. Even if they did not personally experience these practices, many of their parents and ancestors did. Later generations carry these experiences and history through historical trauma.

For these and other groups who have been discriminated against, their history and current relationships with local, state, and federal government are fraught and often marked by distrust and hostility. Their experiences may well affect their willingness to participate in a forensic interview, what questions they will answer, and the kind of information and support they may need to participate.

Finally, older adults are a heterogeneous population with diverse conventions. Therefore, it is best to begin conversations by asking older adults how they wish to be addressed (e.g., Mr., Mrs. Dr., etc.) and using that title throughout the interview. In general, MDT members should not use the person's first name unless asked to do so by the older adult. Then, the MDT member should follow the older person's lead on physical contact and avoid any physical contact unless initiated by the interviewee.

Elder Abuse Dynamics

Reporting Impact

Only a small percentage of elder abuse cases are reported to officials. Those incidents that are reported are rarely initiated by the older victim. For example, in Federal fiscal year 2018, states received 1.7 million reports of adult maltreatment. Of those reports, 45%, or 791,161, were accepted for investigation based on the individual states' program criteria. The majority of those reports (57.2%) were referred to APS by professionals, 10.7% were referred by relatives of the adult, and only 5.2% were self-referrals (Adult Protective Services Technical Assistance Resource Center, 2019).

It is important to understand why cases are rarely reported by those who have been victimized and to recognize that elder abuse tactics often inhibit reporting.

These are some of the reasons for not self-reporting:

- Inability to report
- Victim's fears
- Techniques of the abuser
- Emotional attachments

Perpetrators, Risk Factors, Dynamics, and Justifications

Elder abuse is committed by people in ongoing and trusted relationships with older victims. These are people who are loved, trusted, and relied upon by the older adult. These include intimate partners, family members, caregivers, friends, faith leaders, and cultural leaders as well as fiduciaries such as financial advisors, attorneys, guardians, and agents under a power of attorney. In some cases, relationships may form quickly through a process of grooming and befriending, such as romance or sweetheart scams.

The nature of the relationship separates elder abuse from other crime types committed against older people. It is also why investigating such cases can be laden with impediments. The abuser knows the victim's vulnerabilities, dependencies, assets, and personal history and may use that knowledge to commit illegal acts, avoid detection, and undermine the victim's credibility.

Common perpetrator motivations include greed, power and control (see also "Power and Control"), entitlement, anger, and revenge. Considerable research has been conducted to identify factors associated with elder abuse perpetration and victimization.

Risk Factors for Elder Abuse

Victim characteristics associated with elder abuse include the following:

- **Gender**: Among those age 65 and older, for every 100 men there are 125 women (Administration for Community Living, 2021). Although there are more older women than men, both men and women can be victims of physical, sexual, financial, and psychological abuse and neglect (Acerino et al., 2010).
- **Race**: While the evidence is mixed, several studies have found racial differences in prevalence of financial abuse, self-neglect, and caregiver neglect (Chen & Dong, 2017). Compared with Caucasians, African

American older adults may be at increased risk of financial abuse and psychological abuse, and Hispanic older adults have a lower risk of emotional abuse, financial abuse, and neglect (Pillemer et al., 2016). Non-White elders living in long-term care facilities are at increased risk for abuse and neglect (Hawes, 2003).

- **Marital status**: Some studies have found that being single increases the risk of psychological/emotional abuse, while being divorced or separated is associated with increased psychological/emotional and physical abuse (Chen & Dong, 2017).
- **Relationships and prior abuse**: Some types of elder abuse are associated with previous traumatic experiences, including domestic and other interpersonal violence (Acierno et al., 2010; Storey, 2020).
- **Health and dependency**: Increased risk of abuse is associated with the following characteristics:
    - Persons with intellectual disabilities have the highest rate of violent victimizations, including sexual assault, compared to any other disability type (Harrell, 2015)
    - Physical and cognitive conditions that require assistance with ADLs from others (the risk is unclear for financial abuse because study findings are mixed; Gorbien & Eisenstein, 2005)
    - Impaired ability to care for oneself, defend oneself, or escape the situation (Heisler, 2017)
    - Depression (includes risk of financial abuse; Dyer et al., 2000)
    - Psychiatric illness (Friedman et al., 2011)
- **Social isolation and low social supports**: These are associated with elder abuse victimization (Acierno et al., 2009).
- **Income**: Living in a low-income household is associated with increased emotional/psychological and physical abuse (Chen & Dong, 2017).
- **Age prejudice**: This is another risk factor for elder abuse. Ageist stereotypes can allow negative beliefs and attitudes toward older adults to persist, resulting in neglect and abandonment along with emotional, financial, and physical harm (Shepherd & Brichu, 2020).

Perpetrator Tactics and Motivations

The dynamics of elder abuse are complex; no single theory or model will adequately explain it: "Depending on the victim–offender relationship and the type of abuse, elder abuse may resemble domestic violence, child abuse, or fraud. The phenomenon can stand on its own given the complexity of the relationships, individual vulnerabilities, and contexts in which it occurs" (Amendola et al., 2010, p. 2). Four dynamics that help explain perpetrator behavior are discussed below.

Power and Control/Coercive Control

Most criminal justice professionals have dealt with cases of domestic violence in their careers. Most of those cases involved younger adults. Domestic violence, or coercive control as it is sometimes called, occurs across the lifespan. In younger life, it most often involves spouses and intimate partners. In later life, it may also include children or grandchildren who have lived with and learned domestic violence tactics throughout their lives and now use the same tactics on an aging parent.

Programs worked with increasing numbers of older victims of domestic violence/abuse in later life, many of whom were victimized by adult children using power and control tactics. Based on the experiences of older adults, the National Clearinghouse on Abuse in Later Life (NCALL) created the "Abuse in Later Life Wheel." (See Appendix VI for a visual of the NCALL Wheel.)

In later life, abuser tactics may change from those seen in earlier decades. The use of privilege pervades every other tactic. Commonly observed new tactics include these:

- Abuse of dependency
- Ridiculing the older person's values
- Using family
- Isolating the victim
- Financial exploitation
- Emotional and psychological abuse

Undue Influence

Undue influence is a means to perpetrate financial abuse, sexual abuse, and sometimes neglect by which a perpetrator (the influencer) substitutes their will for the true desires of the victim. Typically, the elements of undue influence include a vulnerable victim, a perpetrator's ability to influence because of a confidential relationship or position of power or trust, the use of tactics to assert this influence, and an unjust result. As an example, California Welfare and Institutions Code Section 15610.70 defines undue influence as "excessive persuasion that causes another person to act or refrain from acting by overcoming that person's free will and results in inequity."

While undue influence is easier to accomplish if the victim has cognitive impairment, it can be perpetrated against anyone who is susceptible or vulnerable. Persons who are lonely, grieving, ill, emotionally dependent, poorly educated, and/or financially naïve are particularly vulnerable to undue influence.

Common perpetrator tactics include isolation from people and information, undermining the victim's confidence in themselves, creating victim's dependence on the influencer, creating fear and insecurity, exploiting vulnerabilities, and gaslighting. Perpetrators may target their victim and engage in grooming behaviors to develop trust and dependence (Brandl et al., 2005).

Older Parent–Adult Child Relationships

Sometimes an older parent may provide care for an adult child who becomes dependent upon the older parent for finances, a place to live, and/or emotional support. The adult child may be experiencing mental health issues, substance abuse, and/or a criminal history, any or all of which can contribute to long-term unemployment. As a result, some older parents may be isolated with their abuser because the older adult is protective of their adult child. As such, they may minimize or excuse the adult child's behavior. Physical, psychological, sexual abuse, and/or financial exploitation can be part of this

dynamic (though less so neglect because the parent is providing care for the adult child rather than vice versa).

Stranger Becoming a Friend/Romantic Partner

In some cases of elder abuse, an opportunistic offender is or becomes familiar with the older adult and ultimately befriends them. The offender engages in a course of conduct, such as providing extra attention and/or services, and gradually ingratiates themselves to the older adult. As a result of the offender's enhanced level of involvement in the older adult's life, the older adult eventually views this person as a best friend or potential romantic partner. The offender then capitalizes on that trust and gains some type of access to the older adult's finances. The older adult, who often feels grateful for the attention, may give the offender gifts or money to perpetuate and bolster the relationship.

In friend or romantic partner types of scams, the offender often fills the companionship void left by the death of a spouse. As the dependency (physical, emotional, etc.) on the offender grows, the offender begins to swindle money from the older adult by expressing a need for help to pay bills or some other expense. They accomplish this by establishing themselves as a kind, caring person who is experiencing a hard time with finances, which is often an effective way for offenders to start having the older adult provide them with money. As offenders gain greater access to the older adult's property and money, offenders will attempt to isolate the older adult from any family or friends who may interfere with their plans. The offender may start to make demands of the older adult, and if the demands are not met, the offender often becomes more threatening.

Offenders who play the new best friend role often start to run errands for the older adult and/or offer to handle the paying of monthly bills. In this process, the older adult provides the offender with their debit card and PIN, bank account information, and other asset information. The older adult is seldom aware that the offender is stealing their money and not paying the bills as promised. Offenders may not limit themselves to just money from bank

accounts—life insurance policies may be cashed in, collectables and jewelry sold, retirement accounts emptied, and lines of credit maximized.

Caregiver-Related Motivations

Many older adults are self-sufficient. However, some do have a caregiver, a relationship in which someone assumes, implicitly or explicitly, a duty to care for another. Caring for an older person, especially one with underlying medical and cognitive conditions is difficult. While most caregivers provide good supportive care, caregivers in elder abuse situations may commit all forms of elder abuse, including neglecting an older adult and causing pain, emotional suffering, serious illness, and sometimes death. Neglect requires that there be (a) a victim who is unable to meet their basic needs for such things as food, clothing, shelter, medications, and bill paying and (b) a caregiver who has a duty to provide needed care.

Reasons caregivers do not meet their caregiving responsibilities include the following:

- They are unable to provide adequate care due to a lack of training, support, financial resources, sufficient physical or mental health. Additionally, they may have special needs of their own, such as a physical or intellectual disability or advanced age or poor health. They may, in fact, be doing the best they can. For example, the loving spouse of decades who is frail and cannot lift their partner is attempting to care for the partner but cannot turn them or get them out of bed, resulting in pressure ulcers and weight loss. Another example is a son with an intellectual disability, is unemployed, and may be without any social support services who is trying to care for his father who is living with dementia and who has developed serious life-threatening pressure ulcers and has sepsis.
- They are the caregiver but are ignoring the needs of their parent with advanced dementia out of indifference while living off the parent's retirement income.
- They are stressed from the burdens of caregiving and as a result are lashing out at the care recipient.

THE AGING BODY

THE AGING BODY

Aging is a process that is different for every person. Older adults experience unique changes in all bodily systems and functioning. These changes are influenced by biological and environmental conditions as well as historical and social contexts across the lifespan.

Biological Changes

In late adulthood, it is typical for people to experience a decline in sensorimotor abilities, but these are not universal and vary from individual to individual. It may take the brain longer to process information, make assessments, and plan a course of action. The slowing of information processing may cause the need for things that were presented quickly or not clearly enough to be repeated.

Vision

Visual acuity can require correction at any age; however, as people age, they may find they need correction, especially for reading or seeing things up close. Depth perception and visual contrast sensitivity may also diminish as age increases. Other age-related visual disorders include the development of cataracts (cloudy areas form on the lens of the eye, causing blurred vision), age-related macular degeneration (AMD; the central part of the retina becomes unable to discern fine details), and glaucoma (buildup of fluid within the eye causes damage to the optic nerve).

MDT members should be aware of these potential biological changes to ensure they are providing materials throughout the investigation that the older adult is able to see and read clearly. Aging also typically effects the amount of light required for the eyes to focus. The interviewer should be

aware of the amount of light in the room during the interview, especially when asking the victim to review documents as part of the interview.

If the MDT member notices difficulty with vision, such as the older adult squinting, they should ask about the use of glasses or contacts. It is not uncommon for glasses to become broken or contact lenses to be lost during an incident of physical or sexual abuse. Perpetrators may also neglect to provide these items to the older adult or even keep them from the older adult as a form of punishment.

Vision impairment may also impact how an older adult experiences an event. As such, when asking questions about what the older adult saw during an alleged incident, MDT members should be aware of how senses can be impacted later in life. The ability to observe specific features such as what the perpetrator looked like or was wearing can be impacted by lighting.

Hearing

Age-related hearing loss results from the degeneration of the structures in the inner ear. Damage to the auditory nerve, hearing pathways in the brain, or other nerves of the inner ear are classified as sensorineural hearing loss, which is the prevalent type of hearing loss for people over the age of 65. For older adults, hearing loss can usually be mitigated by using hearing aids or cochlear implants. Research from John Hopkins University reveals that hearing loss may contribute to an accelerated atrophy of the brain and the subsequent development of dementia (Lin, F. et. al, 2011). Such events may occur due to the negative impacts of social isolation and reduction in mental stimulation following hearing loss (Lin, F. et. al, 2011).

MDT members should be aware of these biological changes during an interview. The MDT member should not assume hearing loss but look for signs that the person is having difficulty hearing, such as the person turning to one side to listen, which may indicate that one ear is better for hearing than the other. If the MDT member notices any behavior that would indicate concerns

about hearing, they should ask the older adult about any hearing issues and preference.

MDT members must consider and understand that signs of hearing loss are not an indicator of the person's cognitive abilities. Thus, the MDT member should not automatically overenunciate or simplify words when communicating with an older adult. When hearing loss is suspected, the MDT member should pay careful attention to these things:

- Using a normal volume of voice
- Using a slightly lower tone of voice
- Slowing down the pace of speech
- Using clear enunciation and not overenunciation that distorts what is being said
- Maintaining direct eye contact throughout all verbal communication
- Reducing nonverbal distractions such as hand movements
- Minimizing any background noise occurring during the interview

The MDT member should ask the older adult if they have a hearing aid and would be willing to use it. Not all older adults routinely wear their hearing aids. A study on use of prescribed hearing aids among older adults found that only 55% use it daily, 27% use it more than 6 hours a day, and 11% never use it (Saloren et al., 2013).

Taste and Smell

Taste buds become less sensitive and decrease in number with age. This decline generally starts during midlife and is not restricted to any one type of taste. Some people will become less sensitive to salt, sugar, and bitter or sour tastes while remaining sensitive to the other tastes (Stevens et al., 1995; Whitbourne, 1999). Taste is often dependent on smell. As we age, the number of olfactory receptors that transmit smells to the brain also decrease in number. Some older adults will lose the ability to smell certain odors (e.g., spoiled food). Changes in taste may impact how an older adult experiences

an abusive event, so MDT members should be aware of how senses can be impacted later in life when asking questions about what the older adult smelled or tasted during an alleged incident.

Motor Function and Strength

Older adults who are sedentary experience atrophy of muscle, increasing the risk of osteoporosis (a condition in which the bones become very thin, porous, and prone to fracture because of calcium depletion), and falls that can result in fractures of the hip, spine, and wrist (American Medical Association, 1998). MDT members should be aware of these increased risks for injuries that may be sustained from a fall or increased susceptibility to injury from abuse and neglect. There may be situations where the injury and explanation do not seem to match but may be realistic depending on the physical condition of the bones or muscles.

Skin

As the skin ages, the nutrient support the epidermis gets from the dermis decreases as surface points of contact between the two layers lessen. Less sebum (oily, acidic, waxy substance) is produced by sebaceous glands in the skin. Sebum's acidity protects the skin against infection. This reduced output of sebum makes older adults' skin more susceptible to disease and skin infections. MDT members should be aware that as skin ages, it becomes more vulnerable to tears from victimization because of less surface contact between the epidermis and the dermis. MDT members should be mindful of the length of an interview when it involves a person sitting or lying in the same position for a long period of time, which could cause significant discomfort for an older adult with skin issues.

- Thinning skin: some medications such as aspirin and anticoagulants may cause bleeding, which may be confused with physical abuse.
- Changes in skin elasticity and reduction in collagen: greater risk of bruising due to abuse or accidental bumping, may be confused with a purpura.

Problematic Injuries and Conditions Suggestive of Abuse

Bruises

Most often associated with physical or sexual abuse, bruises have been studied in elder abuse situations. Two bruise studies, one of older adults with accidental bruising and the other of older adults who had been abused, yielded important distinctions.

An understanding of the findings can help to evaluate information from the older person and to guide in the development of questions to be asked. These are some findings from the study of older adults with accidental bruises (Mosqueda et al., 2005):

- The color of a bruise does not indicate its age. A bruise could have any color from day one. Bruises received at the same time can be of different colors
- 90% of accidental bruises were on the extremities rather than the trunk, neck, or head.
- Less than a quarter of older adults with accidental bruises remembered how they got them.

Older adults taking medications that interfere with coagulation were more likely to have multiple bruises, but the bruises did not last any longer than the bruises of those who did not take these medications. In contrast, when the bruising was due to abuse (Wiglesworth et al., 2009), these were some of the findings:

- Bruises were large. More than half of older adults with bruises who had been physically abused had at least one bruise 5 centimeters (about 2 inches) in diameter or larger.
- While their location could be anywhere, bruises on the face, lateral (same side as the thumb) or anterior (same side as the palm of the

hand) surface of the arm, or on the back are highly suggestive of abuse.

- Older adults with bruises who had been abused had more bruises in these areas than older adults whose bruises were accidental.

Pressure Ulcers

Primarily associated with cases involving neglect, pressure ulcers, also called bedsores and decubitus ulcers, are injuries to the skin resulting from persistent pressure that limits blood flow to the skin. They most frequently occur to the skin that covers bony prominences of the body such as the heels, ankles, hips, shoulder blades, spine, and tailbone. Pressure ulcers are a particular risk for people who, due to medical conditions, are unable to change their position, have limited mobility, or have compromised blood circulation (e.g., from diabetes, vascular disease). Incontinence can cause the skin to break down because it may expose the skin to urine or fecal matter for an extended time. Poor nutrition and insufficient hydration may also contribute to the development of these ulcers. Pressure ulcers may develop within hours, or they can manifest over days, weeks, or months.

The friction of skin rubbing against clothing or bedding can make compromised skin susceptible to pressure ulcers. Pressure ulcers may also appear from shear, which happens when two surfaces move against each other in opposite directions. For example, sliding a patient across bedsheets or removing adhesive bandages from skin may result in significant skin trauma, especially for older adults whose skin has become thinner and more fragile.

Pressure ulcers can be painful, and some potentially life-threatening complications may arise, including the development of cellulitis, a skin infection typified by redness, warmth, and swelling of the affected area; osteomyelitis, a bone infection that can reduce functioning of the bone or joint; and septic arthritis, an infection of a joint that can damage tissue and cartilage.

Pressure ulcers cannot be precisely aged, so experts cannot say how long it took for a pressure ulcer to reach a particular stage. Some generalities may be attempted—stage 1 in hours, stage 2 in days, stage 3 in weeks, and stage 4 longer than weeks—but they cannot reliably indicate how many hours, days, weeks or months. There are also unstageable pressure ulcers in which the

ulcer is filled with debris, bodily fluids, and dead skin. These are typically infected and can result in death. It can take months with proper care to close an ulcer that has reached stage 3 or 4.

MDT members should understand that pressure ulcers are often a symptom of neglect but by themselves are insufficient to prove neglect has occurred. They may not be universally preventable due to underlying comorbidities. Medications such as corticosteroids can make the skin even more fragile. MDTs should avoid long interviews that result in the person being in one position for an extended time. The interviewer should provide breaks that allow for repositioning the person.

The Role of Medications

Certain medications can result in confusion or delirium and may be confused with symptoms of dementia or diminished capacity. The dosage of medications in older adults may need to be less because an older body does not process the medications as it did in younger life. Medications in older adults may react differently in later life than in younger life when prescriptions, herbal supplements, vitamins, and over-the-counter medications are used together.

Medications may be a tool to improve health, but it can also signify abuse (as a "chemical straitjacket") to obtain compliance, keep a person quiet, or cause confusion so they will sign a legal document or make a significant gift.
If the older person knows, the MDT member should explore what medication has been prescribed and for what, which medications have been given to the victim and how they affect the older person, and what medications have been prescribed but not given to the victim.

GENERAL CONSIDERATIONS FOR
COMMUNICATING WITH OLDER ADULTS

GENERAL CONSIDERATIONS FOR COMMUNICATING WITH OLDER ADULTS

The Aging Brain

The aging process affects the brain across the lifespan. These changes influence how people remember, plan, organize, make decisions, learn, and apply new information. MDT members must realize that older adults, like all other victims, must rely on their brain functioning to deal with the wide array of needs that are present. As victims of abuse, they must often navigate a variety of complex systems using their brain functioning to successfully meet these needs. For example, older adults will use their brain functioning to decide whether the forensic interviewer or other MDT member is someone who can help them meet their needs after the abuse. In other words, the brain will attempt to figure out how the MDT member and the interview serve the older adult’s needs, such as the need for justice, emotional well-being, or even the help with ADLs.

In comparison to younger adults, the brains of older adults have more experience functioning to meet these needs. Older adults are much more sophisticated at this than younger adults and children. This does not mean they always make the best choices for themselves or even for the purposes of the interview, but it does mean the aging brain’s experience at meeting needs is complex and difficult to fully understand because a lifetime of variables play a part.

Normal Changes in the Aging Brain

The aging brain means some changes in brain functioning for all older adults. For some individuals, it means very minimal changes, whereas others will experience more significant changes in the brain and how it works to meet their needs.

Normal aging of the brain can lead to decreased speed in finding words and recalling names, difficulty with multitasking, and decreases in the ability to pay attention (National Institute on Aging, 2020). These are due to the slower processing speed of aging brains and underlie attention impairments among older adults (Suchy, 2016). For example, selective attention declines with age. Engaging in a conversation in a noisy restaurant becomes more difficult with age because the ability to selectively attend to relevant information is increasingly impaired. For MDTs, this underscores the importance of a quiet area to communicate with the older adult free of distractions to ensure the older adult is able to attend to the conversation.

Divided attention also declines with age. For example, the ability to talk on the phone while preparing a meal becomes increasingly difficult because it requires cognitively switching between tasks. The implication for MDT members is to have the older interviewee focus on one task at a time and avoid multitasking (e.g., filling out paperwork while being asked questions).

Not all effects of aging on the brain are negative, though. Older adults often have more extensive vocabularies and a greater understanding of the depth of meaning of words than younger adults and children. According to Harvard Health (2015), older adults also often get better at inductive reasoning, accentuating the positive, attaining contentment, and verbal abilities.

The research on the aging brain is rapidly evolving, and it is beyond the scope of this curriculum to teach about every aspect of how the brain changes over the lifespan. Understanding that there are normal changes that will affect functioning such as memory is critical to conducting a strengths-based quality investigation. The older adult victim of abuse is not just forgetful—they

forget things because the brain is not storing and/or recalling information as it did when it was younger due to the natural changes that can affect how it functions.

Addressing Normal Aging Brain Changes in Older Adults

There are three practical approaches to interviewing older adults based on the general characteristics of the aging brain. These can be considered basic approaches without overgeneralizing.

First, don't treat older adults just like younger adults. This doesn't mean that the MDT member should assume that the older adult is forgetful or cannot handle multitasking, but the MDT member does need to be aware that there may be differences. These differences aren't simply because the person is old, but because the brain is naturally changing and affecting behavior.

Second, when a member of the MDT notices differences, ask the older adult what they might need to help them. The team can also check with a trusted family member or other people who are accompanying them, with permission from the victim. Some older adults may need things in writing. Some may need the MDT member to repeat something a few times. Some people may need to focus on one task at a time. Ask the person and accommodate their specific individualized needs whenever you can.

Third, and maybe most important, be patient and give sufficient time for the interview and other investigative steps. When working with older adults, the MDT member should make sure they have time to account for any of these issues that may arise. Rushing an interview and not making time for accommodations will almost never result in an effective interview.

Considerations for Communicating with Older Adults

Throughout the investigative process, MDT members must remember that the adult is the expert on their lived experiences. Keeping this perspective will allow for the MDT to create a victim/witness-centered environment that prioritizes gathering information the older adult knows rather than placing emphasis on what the interviewer or MDT needs to know. Poor questioning techniques affect an older adult's ability to recall and report information during an interview (Love, 2015; Yarmey, 2000).

As discussed previously in "Biases and Assumptions about Aging," in order to remain open-minded, objective, and neutral, MDT members must acknowledge and challenge any biases and assumptions about the older adult population, the credibility of older adults, and the dynamics of cases involving older adults. MDT members must acknowledge that how they perceive the older adult may skew an older adult's ability to recall and report information (Allison & Brimacombe, 2014).

Communication Style of Older Adults

When entering a conversation with an older adult, it is important for MDT members to have a basic understanding of the communication style of older adults. MDT members may notice the use of the following when communicating with an older adult:

- Negative Qualifiers (e.g., "I think," "I'm not sure," etc.)
- Pacing
- Language
- Details and Narrative Organization
    - In general, older adults may provide fewer details spontaneously than in interviews with younger adults.
    - Older adults may relay information out of chronological order.
    - Older adults tend to go beyond the details.

In considering all of these common features when assessing the communication style of older adults, interviewers and MDTs should be mindful

of assigning any meaning or value to the manner in which older adults communicate. When interviewers and MDTs perceive the communication behaviors of older adults in a negative light, this is likely to create a situation where the older adult is dismissed (Allison & Brimacombe, 2014). The way an MDT member perceives an older adult affects the way that they speak—they may adopt a more condescending or patronizing tone that is damaging to rapport with the older adult and information gathering throughout the interview and investigation (Allison & Brimacombe, 2014).

Considerations for Questioning Techniques

MDT members should be mindful of how questions are worded when interacting older adults. Questions must be worded with the individual older adult's ability to understand in mind. (See "Leading and Suggestive Question Types" section.)

MDT members should avoid all of the following:

- Leading and suggestive language
- Negative language
- Figurative language
- Professional jargon/technical terms
- Vague language
- Compound or complex questions
- Stacked questions
- Questions that begin with "why"
- Patronizing style speech or tone of voice

MDT members should instead utilize the following:

- Strengths-based language (see https://info.nicic.gov/sites/default/files/Strength-Based%20Approach.pdf for suggestions on the "strengths-based approach")
- Questions posed in a neutral manner using language that would be used in interviews with a younger adult
- Clear and concrete language

- Prompting cues that incorporate the older adult's words
- Interview pacing that is set by the older adult
  - Word pacing as set by the older adult
  - Appropriate pausing that allows the older adult to process each question posed
- Polite language to redirect the older adult appropriately and respectfully if they become distracted or withdrawn from the topic
- Culturally appropriate language and cultural humility that respect the aspects of cultural identity that are most important to the older adult.

Leading and Suggestion

Individuals of all ages are susceptible to leading and suggestive questions. Memory is not a complete copy of events as they transpired. Instead, memory of an event depends on the information that is encoded at the time of an event (Howe & Knott, 2015). This encoding is affected by what an individual pays attention to or is focused on during the event, which can be affected by a variety of different circumstances (Howe & Knott, 2015). Every time a memory is retrieved, it is reinforced, but it may experience slight alterations due to intrusions of similar memories (Hines, 2018). The memory retrieved is not of the original event but rather the memory of the last time the event was thought about (Hines, 2018). **These are some of the many reasons MDT members must consider the suggestibility of their questions when interacting with alleged victims and witnesses of all ages.**

Similar to children and young adult eyewitnesses, research into the suggestibility of older adult eyewitness suggests that older adults may be susceptible to the effects of misinformation following an event (Memon et al., 2013). In addition, research indicates that older adults may have difficulty identifying the source of the information (e.g., something they witnessed or something heard from someone else; Memon et al., 2013; Mitchell et al., 2003). Older adults tend to have impaired source monitoring, which means when they are being asked where or from whom they learned a piece of information, they may not be able to provide the source, but this does not mean they are lying or hiding something. Thus, interviewers should consider

the suggestibility of their questions when interviewing older adults. MDT members should be mindful not to contaminate memories through asking leading and/or suggestive questions intentionally because this may skew memories/details provided throughout the interview and the criminal justice process. In general, leading and suggestive questions decrease the opportunity for independent responses while increasing the risk of inaccurate information.

MDT members must be aware of their own biases and how they could potentially affect an older adult's memory through their line of questioning (e.g., preconceived ideas about a situation, preconceived ideas about victim/witness behaviors, confirmation bias, etc.). When MDT members are not aware of their biases and use suggestive questioning, they run the risk of receiving influenced, inaccurate information and increasing the risk of skewing an older adult's memory of the details of an event. This could be potentially problematic when attempts are made to corroborate the accounting of an incident. To combat this, interviewers should place emphasis on gathering information that is known by the older adult rather than emphasizing what the MDT needs to know. For MDT members who have been trained in some interview and interrogation techniques, leading and suggestive questions are often encouraged to identify deception or inconsistencies in the accounting of a suspect. While this has been considered a useful interrogation technique, it is less useful when interviewing victims and witnesses of crime.

Question Types

When interviewing older adults, it is important to consider interviewer questioning techniques. Research in interviewing adults of any age has long supported the use of open-ended over close-ended questions as it allows the individual to recall and report their experiences reliably (Brubacher & Powell, 2019; Cassel, Roebers, & Bjorklund, 1996; Geiselman & Fisher, 2014; Poole & White, 1991).

There are four categories of questions to consider when interviewing older adults:

1. Narrative Prompt
2. Open-Focus
3. Choice
4. Yes/No

Narrative Prompt

Narrative prompts are statements that allow the older adult to report everything they know. Prompts are considered more reliable than traditional open-ended questions when interviewing older adults, as they solicit information through free recall. When prompts are posed, older adults commonly respond utilizing more than one word or short phrases.

Examples:

"Tell me everything about your pets."

"You said that you went to the park on Wednesday. Tell me more about going to the park."

Open-Focused

Open-focused prompts are open-ended questions that direct the older adult's focus on a particular response category (e.g., person, place, time). Open-focused prompts often are framed as "wh" questions that allow for a wide range of responses from an older adult (e.g., one-word responses, short phrases, or narrative responses).

Examples:

"What happened after you went to the movies?"

"Who was in the room?"

Choice

Choice questions are close ended that commonly include "or" in the question. Choice questions are posed by giving two or three options in addition to a "something else" option. The "something else" option is essential to reduce influenced, inaccurate information.

Examples:

"Did it happen in the day room, the dining room, or someplace else?"
"Were your clothes on, off, or something else?"

Yes/No

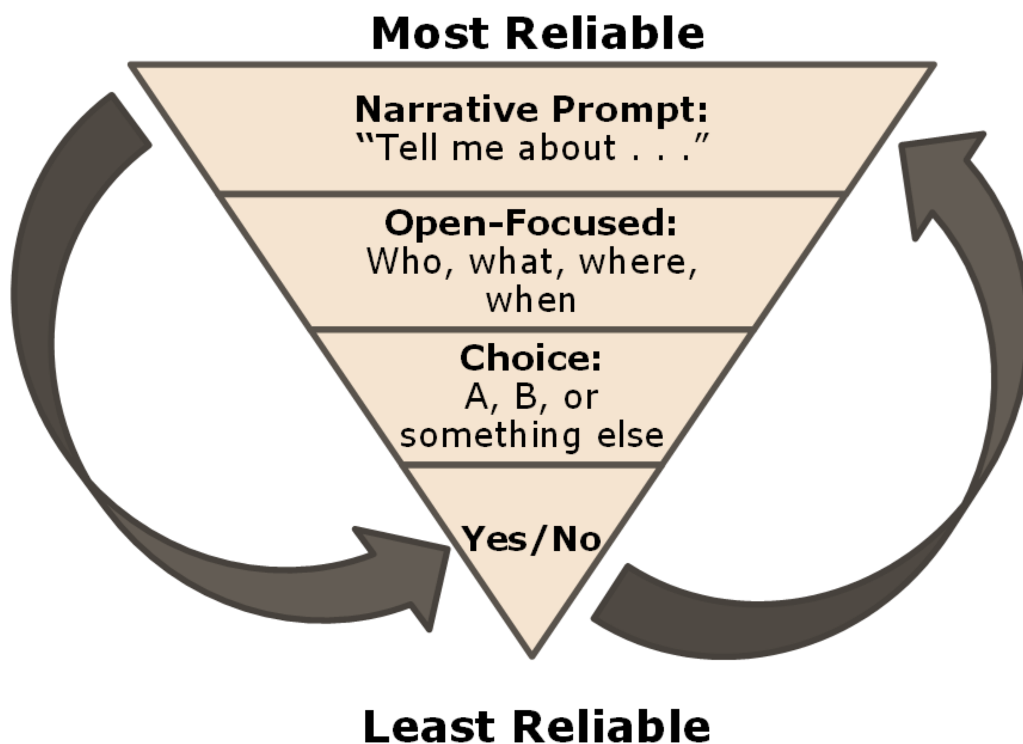
Yes/No questions are closed-ended questions that encourage a one-word response. Interviewers should not rely on yes/no questions alone during a forensic interview with an older adult, as this type of prompt shifts the focus to what the interviewer "needs" to know rather than focusing on the information the older adult remembers. Many individuals will respond with additional information when a yes/no question is posed "yes, and …"; however, interviewers should still limit this type of question as it is not the most reliable way to obtain additional information. Examples:

"Did they have a gun?"
"Did they say something?"

As with any interaction, interviewers are responsible for tailoring the interview to meet the needs of each older adult. When asking questions during an interview, an interviewer should tailor question types posed to match the individual's abilities and needs while utilizing the most open-ended questions possible.

The Recycling Funnel Model

Interviewers should be mindful of the questions they are posing during a forensic interview. To conceptualize this, interviewers may utilize the recycling funnel model. Questions are placed on the funnel based on their openness and reliability in an interview. Narrative prompts are placed at the top of a funnel, while yes/no questions are placed at the bottom end of the funnel, as described by the graphic below.



Each question type serves a purpose during a forensic interview. During an interview, it may be necessary for interviewers to ask choice or yes/no questions in order to obtain important investigative information not otherwise gathered through narrative prompts and open-focused questions. In order to maximize reliable information garnered through the interview process, interviewers should utilize a technique called "recycling." When interviewers pose yes/no questions, they should immediately find opportunities to "recycle" back up the funnel to open-ended questions (e.g., asking *"Tell me about that"* following a yes/no question).

Video Activity: Flossie

Notes:

Cognitive Decline

There are two major types of cognitive decline: reversible cognitive decline and nonreversible cognitive decline. The difference between these two types is extremely important because while their symptoms often look similar, the approach of the interviewer and the quality of the forensic interview are affected differently, depending on which type of decline is involved.

Reversible Cognitive Decline

Not all cognitive decline is due to irreversible conditions such as dementia. Depression and delirium are two medical conditions commonly misdiagnosed as dementia. Disturbances in body chemistry, infection, endocrine disorders, medication reactions, medication overdose, illicit drugs, or alcohol can present similarly to dementia. In addition, many over-the-counter and prescription medications may affect mental acuity. For example, opioid pain medications, benzodiazepines sleep medications, and antidepressants may negatively impact alertness and cognitive performance and should be taken into consideration when interviewing older adults.

Even when someone has a diagnosis such as Alzheimer's disease, these other factors should be ruled out to ensure the older adult can participate to the greatest extent possible. As noted previously, a perpetrator may overmedicate an older adult to purposely keep them from being able to report the victimization. An older adult in early stages of the disease may present as in later stages due to overmedication by the perpetrator. If addressed by a medical professional, the interviewer can attempt an interview at a time when the older adult is properly medicated. This is part of the importance of the MDT for forensic interviewing of older adults to pull in a wide array of resources to assess and address these types of issues.

Irreversible Cognitive Decline

Some conditions cause irreversible cognitive decline. While treatment can slow the progression of these conditions, they are chronic, with an increasing decline in the cognitive processes of the aging brain. These conditions are called neurocognitive disorders (NCDs) in the DSM-V. They are more commonly referred to as dementia. An NCD is a deficit in cognitive functioning that represents a decline from a previous level of functioning not caused by a psychiatric condition. Symptoms include memory impairments, deficits in attention, visual-spatial ability, social cognition, and, importantly, executive functioning.

This curriculum uses the term dementia because it is still the term used by many professionals in the medical field. MDT members should address any bias they have in the use of this term. For example, the term dementia is often used in a way that equates memory loss with forgetfulness, but some types of NCDs do not present until later (or at all) as memory loss.

MDTs should never use the term demented to refer to an older adult. This is not strengths-based or people-first and labels a person in a way that is not medically based. MDT members should use "an older adult living with dementia." Even better for the purposes of a forensic interview is to focus on the symptoms and not a diagnostic label. The MDT can refer to the person as "an older adult with signs of forgetfulness." The diagnostic label is less important than the symptoms that affect the interview. Consider this example in asking about an older adult's family member during pre-interview considerations:

Do not ask: *Does your husband have dementia?*
Instead say: *Tell me about any times your husband has been forgetful.*

If the response includes symptoms of forgetfulness, it is appropriate to follow up to see whether the person they are describing has been medically assessed or diagnosed and is receiving treatment.

Dementia

Dementia is a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities. There are a number of subtypes of dementia. When describing the subtypes of dementia, it is helpful to go back to the DSM-V term of NCDs. By reintroducing that term briefly, the MDT member can understand that these disorders range widely in terms of their etiology. The DSM-V lists these subtypes of NCDs, when you hear "dementia" or "NCD" they can have many different meanings:

- Alzheimer's disease
- Vascular NCD
- NCD with Lewy bodies
- NCD due to Parkinson's disease
- Frontotemporal NCD
- NCD due to traumatic brain injury
- NCD due to HIV infection
- Substance/medication-induced NCD
- NCD due to Huntington's disease
- NCD due to prion disease
- NCD due to other medical conditions
- NCD due to multiple etiologies
- Unspecified NCD

Video Activity: What is Dementia?
Notes:

As should be clear from this list, having an NCD or dementia is not simply a matter of aging. An older adult can experience cognitive decline due to a traumatic brain injury or HIV infection that would not have occurred otherwise.

When dementia does occur, the onset can be slow or sudden. Because of the nature of victimization as described previously, forensic interviewers must be aware of the effects of dementia and how to effectively communicate with older adults living with dementia because it is a significant risk factor for elder abuse when present.

Dementia may affect the ability to recall old information or learn new information. As noted previously, not all dementias affect memory, especially in earlier stages. To be diagnosed, people will experience significant deficits in at least one of the following areas: writing and speech, recognition of people or objects, motor activities, planning, execution of plans, and monitoring of their own behavior. The deficits must be significant enough to affect a person's ability to work or perform daily activities of living or cause problems in social relationship to qualify as dementia.

Inability to complete simple tasks, poor judgment, unrealistic plan making, violent behavior, suicidal ideation, frequent falls or stumbling, disregarding social conventions (making crude jokes, poor hygiene), and levying accusations against loved ones (e.g., that they are stealing property or poisoning the older adult) are some behavioral characteristics of people living with dementia. People living with dementia may be unaware of their condition. Dementia is experienced individually, so while some commonly appearing behaviors are listed, not everyone will demonstrate the same disease trajectory.

Common Subtypes of Dementia

Alzheimer's disease is the most common type of dementia, affecting approximately 5.8 million people in the United States (The Journal of Alzheimer's Association, 2021) and ranking as the fifth leading cause of death for older Americans ("Alzheimer's Disease, Part I," 1998; The Journal of Alzheimer's Association, 2021). Its onset is gradual, followed by progressive degeneration. Memory impairment, language deficits, and declines in visual and spatial processing are typical symptoms of Alzheimer's disease (Cummings, 2004).

In early stages, symptoms typically include the inability to take in new information or recall past events and personality changes, including rigidity, apathy, egocentricity, and impaired emotional control (Balsis et al., 2005). As the disease progresses, symptoms including irritability, depression, delusions, delirium, and wandering are observed. In more advanced stages, language, recognition of loved ones, mobility, and the ability to perform ADLs are lost.

Vascular dementia results from damage to the brain that restricts blood flow, including a series of small strokes, a single major stroke, or other chronic conditions that damage blood vessels in the brain (Mayo Clinic, n.d.). Functional and cognitive deficits are determined by the location of the stroke or strokes or damaged blood vessels. Most people with vascular dementia also have other types of dementia, often Alzheimer's.

Lewy body disease (LBD) is marked by sleep disturbances, visual hallucinations, and visuospatial impairment. These symptoms may occur without memory impairment. Most people with LBD will also develop Alzheimer's, and when that happens, memory loss will occur.

Frontotemporal dementia (FTD) is an umbrella term for several diseases affecting the frontal and temporal (side) parts of the brain. Early symptoms include changes in personality and behavior, and language in early stages memory is not affected. "Some people with frontotemporal dementia have dramatic changes in their personality and become socially inappropriate,

impulsive or emotionally indifferent, while others lose the ability to use language properly" (Mayo Clinic, 2021). In some cases, movement is affected leading to tremors, rigidity, muscle spasms, loss of coordination, swallowing problems, and inappropriate laughing or crying (Mayo Clinic, 2021). Scientists believe that FTD is the most common cause of dementia in people younger than age 60 and that the majority of people with FTD develop symptoms between the ages of 45 and 60.

Stages of Alzheimer's Disease

Regardless of the type of NCD, people will present on a continuum ranging from no symptoms to very advanced symptoms. When working with someone with Alzheimer's Disease, the person will fall onto a continuum of stages based on level of functional impairment. Again, these levels are not solely based on memory or recall but rather signs and symptoms of how the brain's functions are impaired to meet the older adult's needs.

The stages range from no impairment, which occurs when clinical tests (biomarkers) show that Alzheimer's disease is present, but the older adult is experiencing no impairment in functioning, to very severe symptoms impairing functioning, which is often marked by the older adult being unresponsive and in need of care for most functions. The names of the stages can vary depending on the reference source, but they all follow a general pattern from little to no impairment to severe impairment toward the end of life. The progression of these stages will vary significantly from person to person.

Communication Challenges

People living with dementia may experience changes in their ability to communicate. However, it is important not to make assumptions about a person's communication ability or memory based only on their diagnosis or initial presentation. Dementia affects each person differently. Additionally, the changes in communication ability will vary based upon how far the dementia

has progressed. As the disease progresses, an older adult's ability to communicate becomes increasingly impacted. They will follow patterns such as these:

- Have difficulty finding the right word to use
- Repeat stories
- Feel overwhelmed in the presence of excessive stimuli
- Extensively use familiar words
- Describe familiar objects instead of referring to them by name
- Lose track of their general ideas when speaking
- Be unable to answer a question that asks them to describe multiple events
- Be able to provide a linear or chronological answer
- Struggle with the logical organization of words
- Revert to speaking their primary language if they are multilingual
- Verbally communicate less often and rely more on gestures to communicate

Strategies for Communicating with Individuals Living with Dementia:

- Physical Approach
    - Approach victims from the front. Don't come up from the side or from behind.
    - Face the person you are speaking to and refer to them by their formal title (i.e., Mr., Mrs., Ms., Dr., etc.) or preferred name, if known. Utilizing their name will help ensure that you have and keep their attention.
    - Establish and maintain eye contact at eye level as much as possible. Do not require the older adult to look you in the eye. Lack of eye contact may be due to culture, preference, neurodiversity, etc.
    - Minimize speaking with hands.
    - Try to avoid any sudden movements.
- Verbal Approach

  - Introduce yourself and explain that your job is to help them.
  - Develop rapport to decrease anxiety; diminished cognitive functioning does not take away a person's ability to feel anxious or fearful.
  - Do not infantilize the person living with dementia.
  - Speak slowly and clearly while using simple words.
  - Be prepared to reintroduce yourself and your role several times.
  - Keep conversations brief.
  - Keep questions short.
  - Pause between questions as needed.
  - Explain all of your actions prior to doing them. Repeat why you are doing something if necessary.
- Style/Affect
  - Be warm, friendly, and conversational.
  - Use a low-pitched reassuring tone.
  - Do not shout or yell.
  - Try using nonverbal communication along with verbal instructions. For example, if you want someone to sit down, show them by sitting down yourself first.
  - Take breaks as needed.
  - Do not argue with a person or try to orient them to reality.
  - Gently redirect if the individual becomes anxious.
  - Become aware of any triggers (use the Pre-Interview Considerations Checklist in "Appendix I") and avoid them.
- Question Structure
  - Don't get into the exact details of everything you do right away or all at once.
  - Avoid slang and figures of speech.
  - Avoid pronouns as they may become confusing.
  - Use real names for people and objects.
  - Avoid finishing an older adult's sentences.
  - Repeat statements and questions if necessary.

- Give simple, step-by-step instructions, and, whenever possible, a single instruction at a time.
- Avoid saying "I've already told you that" or "Like I said before . . ."

Critical Issues for Communicating with Victims Living with Dementia

MDT members may not always know whether a victim is a person living with Alzheimer's disease and related dementias (ADRD). But if their status is known, there may be some hesitation about communicating with persons with ADRD. Alzheimer's disease and other dementias are progressive conditions that lie along a continuum of severity (Alzheimer's Association, 2021). Persons with ADRD should be interviewed, particularly in the earlier stages of the disease. Further, research confirms that persons with ADRD can report on emotionally meaningful events, such as the experience of elder abuse (Wiglesworth & Mosqueda, 2011). Ensuring persons with ADRD are interviewed as part of a criminal investigation is an access to justice issue. Therefore, regardless of stage—which likely will be unknown—MDTs should always try to interview persons with ADRD and let the courts determine the credibility of the information obtained. Further, the interview may reveal a need for services that otherwise may remain unknown.

With this in mind, there are three critical issues that require attention for MDTs when communicating with persons living with ADRD in addition to the general steps listed in the preceding section: (a) using supportive touch, (b) addressing agitation, and (c) dealing with reality disorientation. Each of these issues are extremely complex and require MDT seek outside expert consultation as needed to address for each individual.

When using caregivers to help determine the best course of action, the MDT needs to be confident the caregiver is not an offender and that they are truly using effective techniques. The MDT should also be aware that just because the techniques work for the caregiver, who has an existing relationship with the older adult, it doesn't mean that the techniques will work for the MDT member who is a new person in the older adult's life.

Video Activity: Kids Interview People with Dementia
Notes:

Using Supportive Touch

Knowing how a person living with dementia responds to physical touch is important. The decision for an MDT member to engage in physical touch should consider the person they are interacting with, how they are doing in the moment, and what the allegations are. **Physical touch should only be considered when initiated by the older adult and should be an intentional decision made by the MDT member that they should be fully prepared to defend, if necessary.** Touch can be utilized as a rapport-building strategy and/or for redirecting the individual back to the conversation.

Addressing Agitation

Like all people, individuals living with dementia read and interpret verbal and nonverbal communication during a conversation. MDT members should be aware that an individual living with dementia may become distressed or agitated by sudden movements, tone of voice, or a tense facial expression, despite the words spoken. MDT members should make sure their body language and facial expression match what is being said by the older adult, even if this might feel a bit forced at times. MDT members should also pay close attention to the body language of the older adult they are speaking with because it will convey interest/disinterest, calmness/anxiety, and aggression.

Persons living with dementia can become quickly agitated and even aggressive, even when talking about non-triggering topics. Safety should always be paramount. MDT members should use language that implies doing an activity together as opposed to language conveying that the person living with dementia must perform the activity alone (e.g., "Let's talk" vs. "Do you want to talk with me?"). Joint activities tend to be more enjoyable, and this technique has success in generating participation in individuals living with dementia (Alzheimer's Society, 2020). If the older adult becomes increasingly agitated, MDT members should utilize de-escalation techniques such as keeping their body language soft and open, using a calm tone of voice, using simple language, asking questions that require a shorter response, redirecting the conversation to a new topic, avoiding arguing with the older adult, and providing supportive statements.

Dealing with Reality Disorientation

When an individual living with dementia introduces difficult questions or becomes distracted by thoughts that are not oriented to the current conversation or what the MDT member believes to be their current situation, employ redirection techniques, and do not directly attempt to reorient them to reality (e.g., telling them that their loved one has died, that they can't go home, etc.). Be as honest as you can be with the individual while you are working on reducing their anxiety and directing them back to the topic that

you were talking about before their attention became focused on a different topic.

Example 1:

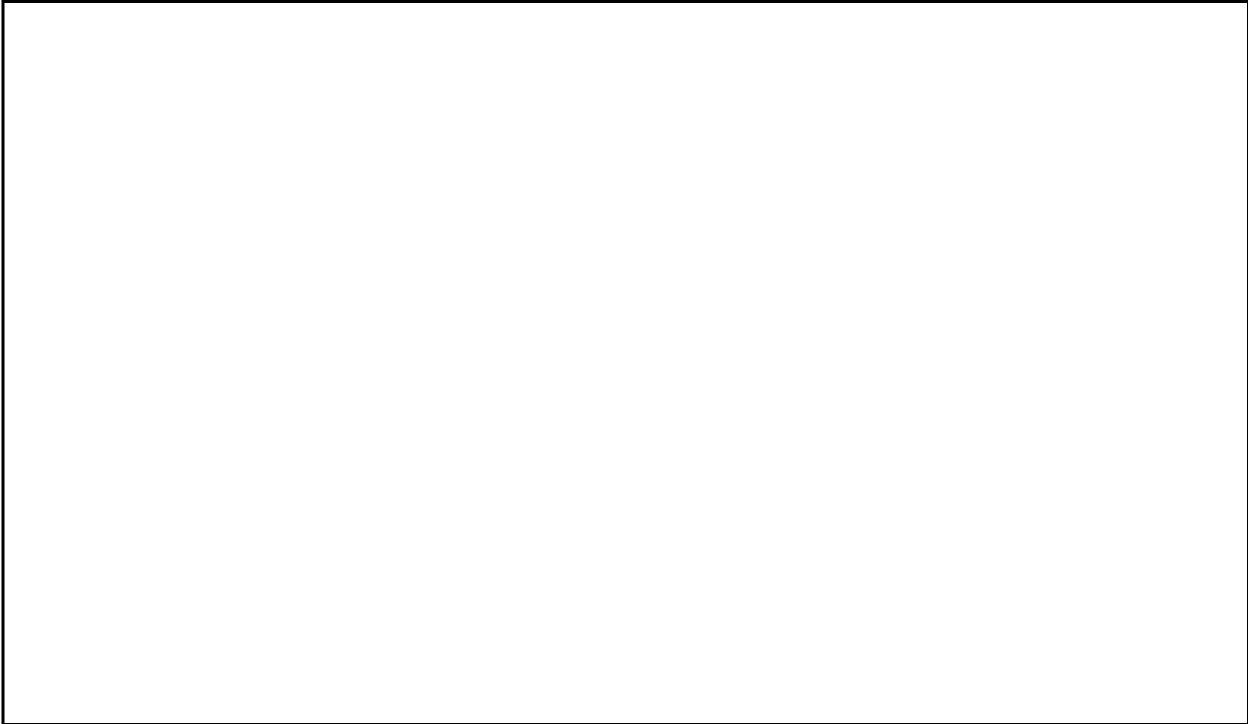
Interviewee:	*Where's my father? I'm looking for my father!*
Interviewer:	*I have not seen him. Tell me about your father.*
Interviewee:	*My father is a good man. I miss him.*
Interviewer:	*Thank you for telling me about your father. I'm not sure where he is, but let me ask someone to find out. Now I'm going to ask you more about _________________.*

Example 2:

Interviewee:	*I want to go home!*
Interviewer:	*Tell me about your home.*
Interviewee:	*I want to go home!*
Interviewer:	*I hear you saying you want to go home. I've never seen your home before—what does it look like?*

If this type of redirection is unsuccessful, consider engaging in an activity that still allows the person to answer questions. If communication stops working, be aware that something grounded in the comfort level may be causing the older adult difficulty participating in the interview. This includes hunger, temperature, having to use the toilet, or pain. Offering to get them a snack, adjusting the room temperature or providing a blanket, or taking a bathroom break may help. If the older adult is observed rubbing part of their body and grimacing, they may be experiencing pain. A person living with dementia may not recognize what is causing them discomfort and simply become unable or unwilling to participate.

Video Activity: Living with Dementia
Notes:



INTRODUCTION TO THE SAFE MODEL OF INTERVIEWING OLDER ADULTS

INTERVIEWING OLDER ADULTS

Interviewing older adults successfully takes time, patience, and the ability to meet the older adult where they are at in the moment. It is important for MDT members to remember that no two investigations will look the same, just as no two people are the same. Below are the semi-structured steps of the SAFE model, along with a brief description of each step. This overview does not serve as a forensic interviewing course, rather an opportunity for all professionals to understand the semi-structured interview process.

SAFE Model Semi-Structured Steps

- Pre-interview considerations
- Establishing rapport
- Establishing interview guidelines
- Establishing a baseline
- Check-in
- Transition to allegation(s)
- Exploring allegations
- Respectful closure

Video Activity: Interviewing Older Adults

Instructions

1. Watch the video.
2. Write down three observations/reactions.

Notes:

Pre-Interview Considerations

Before any interview with an older adult, MDTs should discuss both the interview environment and any needs specific to the older adult being interviewed. The first step in preparing for a successful interview with an older adult is to consider what information may be helpful or beneficial to know ahead of time (as time and consents allow). It is recommended that the interviewer or another member of the MDT utilize either the "Self-Reported Pre-Interview Considerations Checklist" or "Caregiver Reported Pre-Interview Considerations Checklist" (Appendix I). The Pre-Interview Considerations Checklist comes in two forms: Self-Reported and Caregiver-Reported. Each checklist asks information about the older adult, including information about how the older adult communicates or prefers to be communicated with. While not all questions on the checklists are appropriate to ask of every individual, they serve as a guide for MDT members to gather information so the interviewer can be as prepared for the interview as possible.

These tools can serve as a guide for MDTs to gather information about how the interviewer can provide the best opportunity for the older adult to feel successful with the interview process by identifying appropriate accommodations that an interviewer can make in a strengths-based way. This information should be gathered in a trauma-informed way that does not impact establishing trust with the interviewer and older adult interviewee. As appropriate, the older adult should be made aware and give permission for a member of the MDT to have a private conversation with a caregiver.
When preparing to interview an older adult, consideration of any required special accommodations should be made to ensure a successful interview. Accounting for and meeting the needs of an older adult conveys that the interviewer has respect for the older adult and intends to treat them with dignity, which is the foundation of rapport building.

Physical Accessibility

For the older adult population, MDT members should ensure that interview rooms are physically accessible and can accommodate any needed mobility devices (e.g., canes, walkers, wheelchairs). The room should be at a comfortable temperature because some older adults have trouble regulating body temperature. Comfortable, cushioned seating should be provided because older adults may become distracted by physical discomfort if the bony prominences of their hips and spine are pressed against a hard surfaced chair. Sometimes, an older adult may need to be interviewed where they live or sleep or in a hospital room, depending on the physical condition, allegations, and urgency of the interview.

MDT members should ensure that the older adult is in possession of any needed eyewear or magnifying device and that the room is well lit to facilitate the review of printed materials, photographs, etc. Ideally the area around the outside of the interview room should be quiet and without distracting noises inside the room. Older people with mild hearing loss will have difficulties hearing words in the presence of background noise (noisy fan, buzzing light, etc.). When asking questions, interviewers should look at the older adult and maintain an unobstructed line of sight with the older adult. Interviewers should also consider that if the older adult is not making eye contact with them, it may be because of cultural reasons or a history of trauma. If the interviewer is getting non-responsive answers, they should consider first whether the interviewee can hear clearly without assuming cognitive confusion.

Considerations for Scheduling

Deciding when to schedule an interview is another important individual factor to consider when planning to interview an older adult. While it is often best to schedule an interview as quickly as possible after an incident, some instances may require a delay in interviewing the victim/witness (e.g., very traumatic experiences). In addition, MDT members should consider other factors when

considering when to schedule an interview, such as medications, medical needs, schedules/routines of the older adult, and cultural factors.

Ideally, a person should be scheduled for an interview during their typically most alert/active part of the day, and the time of the interview should be considerate of any potentially competing personal interests (e.g., special event). Considerations include the older adult's personal schedule, medication schedule, medication effects, and as mentioned the most alert/active time of the day. Medication administration is also an interview consideration because medication could positively or negatively affect a person's ability to be interviewed. The MDT member should strive to ascertain the effects of any medication taken by the prospective older adult to determine when to conduct an interview. Some medications may make the older adult tired and unable to focus, or they may induce stupor or delirium. Information regarding medication can be obtained from the older adult, a caregiver, adult protective services, or a medical professional.

Certain prescribed medications may cause side effects or hinder an older adult's communication during the interview process. If the person has medical or other personal needs, interviewers will need to monitor for fatigue, the need for breaks, and the need to eat or take medication on a schedule. When inquiring about medications, teams may consider asking questions such as these:

- Does the older adult need to allow time for medications to take effect?
- Are there side effects that need to be considered after medication has been taken?

MDTs must consider the scheduling of an interview when an older adult has medical issues that need to be monitored (e.g., diabetes, timed medication, blood pressure, etc.). For example, if the older adult has diabetes, consideration regarding the availability of drinks and snacks should be made, and depending on the length of the interview, affording them time to check their blood sugar may also become a factor.

Schedules should be considered to ensure the time does not interfere with the

older adult's routine (e.g., wake time, rest time, or bedtime). For example, an older adult with a form of dementia or cognitive impairment will need to stick as closely to their routine as possible. This is necessary to prevent confusion, fear, and anxiety. Any change of routine can be disorienting, so ensuring the older adult is properly rested and continuing to assess their needs is critical. An older adult with a form of dementia may also experience sundowning, which can present as restlessness, agitation, irritability, or confusion that increases toward the end of the day. An interview earlier in the day should be conducted when interviewing older adults living with dementia.

The timing of the interview is also critical. The MDT member should consider whether the older adult may be affected due to when the interview is occurring:

- Before or after a meal
- Before or after the adult has taken medication(s)
- Before or after certain daily routines
- Before or after physical exercise

In general, MDT members should consider mid to late morning for peak cognitive abilities. For people living with dementia, the experience of sundowning may be present, resulting in decreased cognitive abilities and even agitation later in the day. Caregivers can be consulted about their observation on when the older adult will be best able to participate in the interview.

Teams should consider cultural factors when scheduling an interview as well. Teams may consider asking questions such as, "Are there certain times of the day, days of the week, or dates that are special and not to be interfered with?" Examples would include religious holidays, prayer times, religious days of the week, etc.

Interview Environment

As with any other interview, teams should strive to create an interview environment that is neutral, private, comfortable, and non-shaming for the older adult being interviewed. When choosing an interview location, it is critical that teams select an environment that is both physically and psychologically safe for the older adult. **Any concerns regarding safety should be resolved before the interview takes place.** In order to establish a safe and comfortable interview environment, teams must be mindful of the level of authority represented within a location and should work to lessen this dynamic. Teams should avoid interviews in intimidating locations (e.g., interrogation room) or non-neutral locations (e.g., the location where the incident occurred) whenever possible. It is possible that the interviewee may not be able to move to a new location to be interviewed. In these cases, MDT members should be flexible with what is reasonable, safe, and preferred by the older adult. In addition, teams may lessen the appearance of authority by minimizing the number of individuals present during the interview and providing choice to the older adult about the time and place of the interview.

For interviews occurring outside of the older adult's home or facility, teams should work to establish the interview location as a safe environment. It may be beneficial to provide a tour of the location and/or the interview space prior to the interview. If observers will be watching the interview from another room, it is important the team plans for how this will be introduced to the older adult.

Before interviewing an older adult, some of the more specialized information the MDT member should attempt to establish includes the following:

- The older adult's degree of mobility
- The older adult's level of dependence upon caregivers to perform frequent repositioning
- The older adult's daily routine
- The expectations of care as outlined in a treatment/care plan or doctor's orders
- What medications are taken and whether any contribute to skin vulnerability, loose stool, or elevated urination

- Toileting habits
- The caregiver’s body and/or incontinence underwear check routines and recording methods
- Recent history of examination by a doctor or nurse
- Last doctor’s visit or nurse visit

As noted, many of the pre-interview considerations can come from caregivers or family members. The MDT member must be cautious of asking these questions from someone who could be the perpetrator or anyone who may not be seeking the best interest of the older adult.

Informed Consent

Older adult interviewees should be treated with dignity, respect, and transparency throughout the interview process. For this reason, teams should consider obtaining informed consent from the older adult being interviewed. Teams should ensure the individual is aware of each step of the process and their rights. If materials are presented to the older adult, they should include language and/or visuals that are inclusive (e.g., materials available in large print font).

If applicable, these are some things older adults being interviewed should be made aware of:

- The steps of the interview process
- The purpose of recording
- Who the information will be shared with
- Their ability to take breaks or end the interview
- Their right to revoke consent

Individual Needs

The interview environment should be arranged to accommodate the unique needs of the older adult. First and foremost, it is critical that the team

considers an older adult's physical needs. The interview location and space must be Americans with Disabilities Act (ADA)-compliant to accommodate wheelchairs, walkers, canes, or other assistive devices. These spaces should not only be accessible but comfortable to the older adult. When considering accessibility and comfort of the interview environment, teams should also consider the furniture at the interview location (e.g., waiting room, interview room, etc.), such as comfortable chairs for backaches/sciatica and/or bariatric chairs for obese older adults who may have diabetes. Teams should also ensure that bathrooms are accessible with ADA-compliant doors for easy entering and exiting and toilets have a raised seat for easy sitting and standing. Teams should also consider offering drinks and snacks in cases of low blood sugar during and after the interview process.

In addition, teams should consider making modifications to the environment to meet individual needs (e.g., emotional needs, psychological needs, etc.). Making modifications takes preparation, and it is important to understand each older adult's needs prior to their arriving for the interview—the interviewer's role is to meet each individual where they are throughout the interview process. MDT members may inquire about information such as safety concerns for the older adult or interviewer, diagnoses, trauma history, known triggers, cognitive abilities, communication abilities/style, etc. It is also important to gather information about what to do in situations when an older adult becomes triggered or agitated. Teams may consider asking questions about maintaining a calm atmosphere and the forms of redirection and/or de-escalation that are used in the interviewee's daily life.

Although this information can be critical to meeting an older adult where they are throughout the interview process, MDT members should be cautious of drawing any conclusions from information gathered pre-interview. Interviewers should utilize this information as a guide for the interaction but not rely on this information alone. As the interviewer interacts with the older adult, they should maintain objectivity and flexibility and continually adjust to meet the older adult where they are. In addition, it is not the interviewer's role to diagnose or use labels when working with an older adult. MDT members should be cautious of using any labels the older adult does not self-identify

with because it may be damaging to rapport building and gathering reliable information from the older adult being interviewed.

Comfort Items

In some instances, an older adult interviewee may bring comfort items with them to the interview. These could include items such as weighted blankets, pillows, or manipulatives (e.g., stress balls). MDT members should not take away any personal or comfort items during the interview, so they do not appear too authoritarian. Teams may also decide to make comfort items available. If an item becomes a distraction during the interview process (e.g., a cell phone), the interviewer may provide respectful redirection to the interviewee.

Use of Victim Advocates, Support Persons, or Support/Therapy Animals

Older adult victims may desire to utilize support persons (e.g., family members) or professionals (e.g., victim advocates) as they navigate the criminal justice process. These individuals may assist in fostering interviewee comfort, so consideration should be given to their use to remain trauma-informed and victim-centered throughout the interview process. Some older adults may also have a support or therapy animal that will need to be accommodated during the interview process.

Before their inclusion, it is important that teams consider the role a victim advocate or support person will play during the interview and discuss how they will be introduced. Teams may consider adding written policies/procedures regarding working with victim advocates or support persons during forensic interviews while being mindful of victim's rights within a particular jurisdiction.

As discussed previously, teams should limit the number of individuals present during a forensic interview because additional individuals increase the potential of bias being during an interview. However, if a victim advocate or support person is requested to be present during the interview, MDT members should work together with the interviewee when deciding whether they will be

included in the forensic interview. MDT members should explore the interviewee's desire to include the additional party in the interview and discuss both potential risks and benefits to their inclusion.

In general, victim advocates or support persons should be seated out of the line of sight of the interviewee. MDT members and support persons should not speak about the interviewee as though they are not in the room; they should speak directly to the interviewee. And it is imperative that the role of the support person in the interview process is clearly established so the forensic interview is not negatively impacted by their presence. This can be accomplished by the interviewer meeting with the advocate/support person before the interview to clarify their role and understand what the expectations are for their involvement.

It is important that victim advocates/support persons do not speak or interject, which includes the following:

- Asking or clarifying questions
- Answering questions on behalf of the person being interviewed
- Reacting to what is discussed during the interview

Establishing Rapport

Rapport begins with the first encounter, the first encounter could be with any member of the team. Regardless of role, each professional should be aware of how the first encounter impacts the interview and investigation. Rapport is critical because when older adults feel comfortable, they provide a greater amount of and higher-quality information (Marche et al., 2014). This requires team members investing time to develop meaningful rapport with the older adult.

Establishing meaningful rapport serves to:

- Create a relaxed and supportive environment
- Reduce the older adult's anxiety
- Establish trust between the interviewer and older adult

- Help the interviewer get to know the older adult and create a baseline for the interviewer to:
  - Identify strengths
  - Identify cognitive and social issues
  - Identify cultural considerations
  - Assess the older adult's comfort level
  - Assess the older adult's mode of communication

A critical rapport-building step for older adults is asking how they would like to be addressed. Unlike most interviews with children and even some adults, the preferences of older adults on how to be addressed can range significantly. The interviewer should not assume calling an older adult "sir" is preferred. Sometimes this may be appropriate, but other times the older adult will respond that sir is their father, as that is how they were to refer to their father. Even the use of nicknames may be appropriate to use for older adults. For example:

Interviewer:	*Hi, Martha Jones. My name is ____________. How would you prefer I address you as we are talking here today?*
Martha Jones:	*All my friends call me Marty.*
Interviewer:	*Do you mind if I call you Marty?*
Martha Jones:	*Just don't call me Martha. My parents and teachers were the only ones to call me that.*

Establishing Interview Guidelines

Interviews are structurally different from a conversation and may be unfamiliar to older adults. Therefore, it is important to introduce interview guidelines to orient an older adult to the expectations of the interview. Setting guidelines for both the interviewer and the older adult being interviewed will decrease suggestibility and empower the older adult. Interview guidelines should be considered in the context of the individual's strengths and the potential impact each guideline might have on the process.

There are five guidelines to consider when interviewing older adults:

- Don't know/don't guess
- Don't understand/doesn't make sense
- Correct me
- Don't want to talk about it
- Say it when you remember it

Establishing a Baseline

Establishing a baseline for communication with an older adult helps interviewers continue rapport development with the older adult and set a mutual understanding for how questions will be asked. Through this process, the older adult learns the level of detail expected throughout the interview process by practicing narrating about a neutral event (e.g., an activity or recent event of interest to the older adult). Baseline development provides an opportunity for the older adult to demonstrate their abilities through the providing of information about a specific episode (i.e., event) by accessing episodic memory, as they will be asked to do later in the interview.

Check In

Before moving on with the next phases of the interview, it is important to check in with the older adult. The interviewer may check in about how the older adult is feeling so far and whether they have any questions about the interview process. They may respond with questions or potential blocks and barriers; interviewers should work to assess the reasoning behind the question and/or any blocks and barriers and provide legally defensible responses and/or reassurance to the older adult as needed.

Small Group Activity: Overcoming Blocks and Barriers • **Read the victim information and case referral for "Judy"** • **Work with your group to answer the questions below** • **Designate a spokesperson to report back to the large group**
Victim Information-Judy
Judy is a 92-year-old woman who had a stroke 10 years ago. Judy is not able to ambulate on her own and has limited use of her left arm only. Although she can feed herself certain foods (finger foods, easily scooped with a spoon or stabbed with a fork), she requires total care for all of her activities of daily living. Her daughter, Margaret, has been responsible for Judy's care for the last 9 years. Judy was widowed twenty-nine years ago. Judy has a slight slur to her speech but is easily understood, especially as someone is around her more. Judy dedicated her adult life to Margaret, who was an only child. Judy was a troop leader for Margaret's girl scouts' troop for several years. Judy attended every school event/activity to support Margaret. Judy and her husband, Joseph, gave Margaret everything that she needed to be successful in life. Judy's fondest memories are of the times they spent taking a family summer vacation at the lake. Margaret decided not to go to college and took a job as an assistant in a veterinary office. When Margaret volunteered to take of Judy, Judy was thrilled that her daughter would be with her, taking care of her. Judy believed that Margaret would be the best person to take of her. Judy wasn't comfortable with strangers coming into her house especially since she wasn't able to move about on her own.

Case Referral
Margaret was not providing basic care for her mother. EMS responded to Judy's house and found her in a state of medical emergency. Judy was taken to a hospital where she was diagnosed with severe sepsis, severe skin breakdown, dehydration, and pneumonia.
1. **What three blocks and barriers to you anticipate during the interview/investigation involving Judy?** 2. **What strategies might you use to overcome those blocks and barriers?**

Transition to Allegation(s)

Transitioning the conversation to the reason for the interview, typically allegations of abuse or neglect, can happen in a variety of ways. It is essential for the interviewer to start with the most open-ended option, taking into consideration the strengths, established baseline, and communication style of the older adult. The jurisdiction and input of the investigative team should also be carefully considered.

Exploring Allegations

Once the allegation(s) or concerns have been identified through one of the transition options, interviewers should continue to gather reliable information about the allegations through the same format used during baseline development. It is important that interviewers continue to ask open-ended questions to avoid assumptions about what did or did not happen, and they should have multiple hypotheses and explanations in mind prior to the interview to remain as objective and neutral as possible.

In the same way that was used while establishing a baseline, the interviewer must remember that the older adult controls the information as the expert of their experiences, while the interviewer guides the flow of information. An interviewer's purpose is to make the individual being interviewed as successful as possible by asking questions that help the older adult provide information through free recall and by asking questions that help the older adult's thoughts remain as organized as possible.

Respectful Closure

The purpose of providing respectful closure is to provide a gentle transition from exploring allegations and end the interview session. To transition to closure, the interviewer should probe for any additional information the older adult would like to discuss.

Depending on the role of the professional involved, a full interview may not be appropriate and mandated reporting procedures should be followed. This is essential to the well-being of the individual, as it is most trauma informed for the older adult to not have to repeat their accounting, but also is best for maintaining the integrity of the case. While this training outlined some tools and strategies for communicating with older adults, this is not a full forensic interviewing course, and the gathering of specific case related information should be conducted by a multi-disciplinary investigative team.

Post-Interview Considerations

Post-Interview Team Conference

Any involved team members should meet after the interview with the older adult to accomplish these things:

- Share information from all sources, as appropriate
- Determine what immediate services are needed
- Identify other issues to be considered before moving forward
- Discuss any next steps with the older adult or any family/support person/caregiver (with the older adult's permission)

These are some topics for consideration when discussing next steps with the older adult or any family/support person/caregiver (with the older adult's permission):

- The results of the interview
- Safety planning
- The next steps in the investigation
- Any concerns about the individual being in crisis, which would indicate a post-interview crisis assessment
- Appropriate follow-up and referrals for counseling, medical care, questions about the legal process, etc.
- Connecting the older adult and any family/support person/caregiver to resources

Post-Interview Crisis Assessment

A post-interview crisis assessment may be indicated, especially in situations when an individual appears to be in crisis, as identified by the older adult; a team member; or a family member, support person, or caregiver. This crisis assessment should be conducted by a mental health professional with expertise in trauma and crisis intervention. It should focus on individual's immediate mental health status and needs, especially including an assessment for suicidal ideation.

Vicarious Trauma Considerations

The interviewer and the rest of the investigative team should be aware of the possibility of vicarious trauma and possible impact. This is not only important for the individual team members but also for the individuals they are interviewing and the caregivers they interact with. The team should have an open dialogue about possible vicarious trauma and any impact this may have on the interview and investigative processes.

Interviewers and team members should use available resources to discuss vicarious trauma and take any necessary steps to cope with and manage symptoms of vicarious trauma:

- Identify whether there are any issues related to the interview that are causing any secondary traumatic stress for the involved team members
- Discuss these vicarious traumas with the team members present and include others if needed
- An affected team member should consider withdrawing from meeting with family or involved caregivers if their involvement may negatively impact the wellbeing of anyone involved

APPENDICES

APPENDIX I

Pre-Interview Considerations Checklists

When preparing for a forensic interview with an older adult, it is important to gather information from caregivers, and/or service providers (family members, staff members, care providers, etc.) or the individual themselves to learn more about how that older adult communicates. These conversations should happen before every interview if possible and appropriate. If a caregiver is available and the team does not have any concerns about the caregiver being involved with abuse or neglect at the time, they should utilize the "Caregiver-Reported Pre-Interview Considerations Checklist" to gather some additional information. There may be some instances when gathering information from a caregiver would cause potential danger to the older adult, in that case, interviewers and teams should always ensure that safety is paramount.

In general, older adults should be informed of the purpose of the interview. If the older adult being interviewed is able to answer questions for themselves, interviewers may utilize the "Self-Reported Pre-Interview Considerations Checklist" to gather some additional information.

These checklists are not intended for interviewers to ask every question listed, rather as a set of prompts to consider when gathering information about how the older adult communicates.

Caregiver Reported

Pre-Interview Considerations Checklist

Examples of Prompts:

Communication:

- ✓ How does the interviewee communicate?
- ✓ How do they get their needs met?
- ✓ Do they understand what is being said to them?
  - If so, how do you know?
  - Do they correct you if you say something wrong?
    - If so, what do they do?
- ✓ Are there times that they are forgetful?
  - If yes, tell me about a time.
- ✓ Does the interviewee require an interpreter?
  - If yes, for what language (e.g., ASL, tactile, pro-tactile, etc.)?
  - What are the interviewee's interpreter preferences?

Daily Life:

- ✓ What are some potential topics to discuss with them to build rapport?
  - What activities do they enjoy?
  - How do they typically spend their day?
  - Have they gone to any recent events or done anything exciting that they might want to share?
- ✓ What is their level of independence with activities of daily living?
  - Do they need assistance with bathing? Toileting? Dressing? Ambulating? Eating? Other?
- ✓ What are the mobility needs of the interviewee and/or caregiver?
- ✓ What is the best time of day to conduct an interview? Worst time of day?
- ✓ Does the individual take any medications?
  - If yes, were they taken today?
  - Are there any side effects?
  - How long have they been taking medications?
  - Are they taking medication consistently?
- ✓ Do they have a safety plan?

Accommodations:

- ✓ What sensory needs does the interviewee have?
  - Do they have any sensory defensiveness (smells, sounds, volume, textures, etc.)?
- ✓ Does the interviewee have any comfort items (fidgets, weighted blankets, personal items)?
- ✓ What other conditions does the interviewee have?
  - Do they have any comorbidities?
  - Do they have any diagnoses?
- ✓ What is the interviewee's trauma history?
- ✓ What are their triggers, and how do you overcome them?
- ✓ If interviewee shuts down, what is the best way to respond?
- ✓ How do you help the interviewee respond to new situations?

Self-Reported
Pre-Interview Considerations Checklist

Communication:

- ✓ What is your preferred language?
- ✓ Do you prefer to use an interpreter?
    - If yes, for what language (e.g., ASL, tactile, pro-tactile, etc.)?

Daily Life:

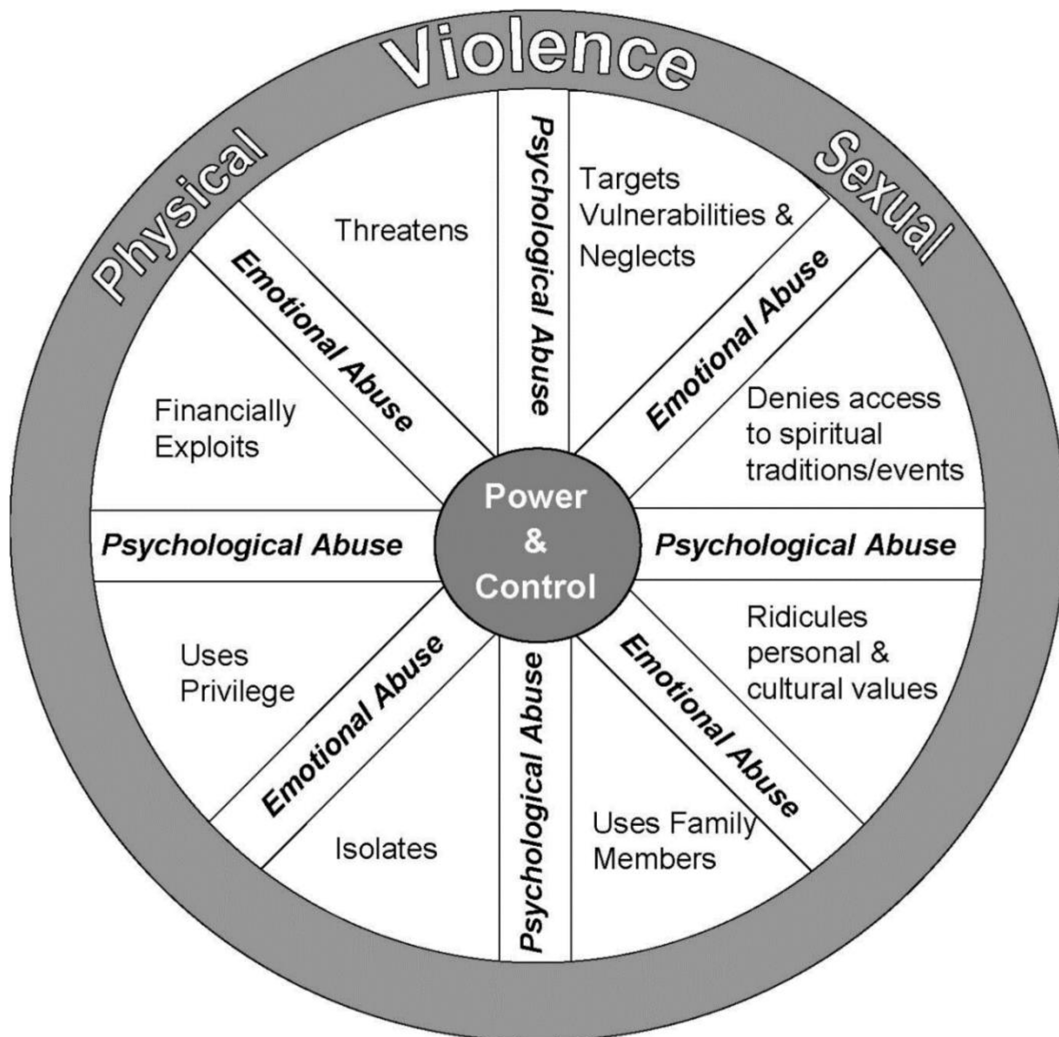
- ✓ What is the best time of day to talk with me?
- ✓ Does anyone come help you during the week?
    - If yes, who and how often?
- ✓ Are you currently taking any medications?
    - If yes, were they taken today?
    - Are there any side effects?
    - How long have you been taking these medications?
    - Are you able to take them consistently?
- ✓ What are some activities that you enjoy?
- ✓ How do you typically spend your day?
- ✓ Have you done anything lately that you enjoyed that you would like to share with me?

Accommodations:

- ✓ Do you require any accommodations to come to our building?
- ✓ Where would you prefer to have a conversation with me?
- ✓ Is there anything you can think of that would make you more comfortable during our conversation?

APPENDIX II

Power and Control Wheel



APPENDIX III

Elder Abuse Terms Defined

Term	Definition	Additional Information
Guardianship/Conservatorship	Person or company appointed by a court to make decisions on behalf of a person who is lacks decision making capacity	• Authority to make personal and/or financial decisions for a person found by a judge or jury to lack capacity to make those decisions • Different jurisdictions may call the appointed person a guardian or a conservator • Court issues letter or orders describing the decisions the guardian or conservator may make • Authority may be limited or plenary (full power) • Court monitors acts of guardian or conservator to extent provided for by local laws • Guardian or conservator is a fiduciary so they must act "in a totally trustworthy manner and make decisions that are consistent with decisions that the incapacitated person made before losing decision-making capacity or that are in the incapacitated person's best interest." (Stiegel, 2014, at p. 23) • Misuse of authority may be a crime, usually a form of financial abuse or financial crime

Powers of Attorney (POA)	A legal document in which a person with capacity (called the principal) gives authority to another person (called the agent or attorney-in-fact) to act for the principal	- Not created by a court; not monitored by a court - Principal must have decision-making capacity when creating the POA - Principal can revoke the POA or change agents as long as the person has decision-making capacity - Principal is a fiduciary so must act "in a totally trustworthy manner and make decisions that are consistent with decisions that the incapacitated person made before losing decision-making capacity or that are in the incapacitated person's best interest." (Stiegel, 2014, at p 35) - POAs terminate with the death of the principal unless revoked "Durable POAs" allow the agent to act on behalf of the principal after the principal loses decision-making capacity - Misuse of authority under a POA can be a crime, often a form of financial elder abuse or financial crime.

Health Care Power of Attorney (POA), Health Care Proxy, and Living Will	Advanced directive providing directions regarding the principal's health care once that person is unable to make or express those decisions	• Health care POA or proxy allows principal to appoint someone else (called the proxy or agent or attorney in fact) to make health care decisions for them • Living will instructs the proxy or other decision-maker such as a guardian or conservator or health care provider about the kind of care, including end of life or emergency treatment the principal wants or does not want • Principal must have decision-making capacity to make an advanced directive • Misuse of health care proxy/POA may be a crime such as elder abuse, neglect, and financial crimes

APPENDIX IV

SCAMS

Health Insurance Scams: There are health insurance scams that speak to the older adult via phone, email, or at the door requesting personal information from the older adult due to a problem with their insurance. The common information requested is name, address, date of birth, and social security numbers.

IRS Scams: An IRS scam happens when someone pretends to be the IRS, typically on the phone. The common information requested is name, address, date of birth, social security numbers and bank account information.

Pigeon Drops: Scams that request the older adult to send the perpetrator a "smaller" sum of money needed to help the perpetrator deposit a larger inheritance. The older adult is usually promised half or other amount of the inheritance for helping, which never happens.

Other scams are seen below (seniorliving.org, n.d.):

- Telemarketing
- The Fake Accident Scenario
- Robocalls
- Charity Scams
- Internet Fraud
- Tech or Computer Support Scams
- Lottery and Fake Prizes Scams
- Counterfeit Prescription Medication Scams
- Fake Anti-Aging Scams
- The "Grandparent Scam"

- Investment Schemes
- Mortgage Scams
- Funeral Fraud
- Fake Magazine Scams

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ElderJustice INITIATIVE

This training was produced by the Modell Consulting Group, LLC pursuant to a contract awarded by the U.S. Department of Justice's Elder Justice Initiative. The opinions, findings, and conclusions or recommendations expressed in this training are those of the contributors and do not necessarily represent the official position, policies, or views of the U.S. Department of Justice.