

Feature Article

The Gerontologist
Cite journal as: *The Gerontologist* Vol. 54, No. 2, 153–162
doi:10.1093/geront/gnt139

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Advance Access publication November 22, 2013

Elder Abuse: Research, Practice, and Health Policy. The 2012 GSA Maxwell Pollack Award Lecture

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Received September 10, 2013; Accepted October 9, 2013
Decision Editor: John Williamson, PhD

Elder abuse, also called elder mistreatment or elder maltreatment, includes psychological, physical, and sexual abuse, neglect (caregiver neglect and self-neglect), and financial exploitation. Evidence suggests that 1 out of 10 older adults experiences some form of elder abuse, and only a fraction of cases are actually reported to social services agencies. At the same time, elder abuse is independently associated with significant morbidity and premature mortality. Despite these findings, there is a great paucity in research, practice, and policy dealing with this pervasive issue. In this paper, I review the epidemiology of elder abuse as well as key practical issues in dealing with the cases of elder abuse. Through my experiences as a Congressional Policy Fellow/National Health and Aging Policy Fellow, I highlight key provisions on 2 major federal legislations dealing with the issues of elder abuse: Older Americans Act (OAA) and Elder Justice Act (EJA). Lastly, I highlight major

research gaps and future policy relevant research directions to advance the field of elder abuse. Interdisciplinary and community-based efforts are needed to devise effective strategies to detect, treat, and prevent elder abuse in our increasingly diverse aging populations. Collective advocacy and policy advances are needed to create a national infrastructure to protect the vulnerable older adults.

Key Words: Elder abuse, Epidemiology, Health policy, Maxwell Pollack lecture

Elder abuse, also called elder mistreatment or elder maltreatment, includes psychological, physical, and sexual abuse, neglect (caregiver neglect and self-neglect), and financial exploitation (National Research Council, 2003). Over the last few years, there have been significant national discussions on the topics of elder abuse. In June 2010, the National Institute on Aging and the National Academies of Sciences hosted a state-of-science conference on elder abuse and highlighted the research progress as well as the vast gaps and recommended research priorities. In March 2011, the Senate Special Committee on Aging held a

An earlier version of this article “Elder Abuse: Research, Practice and Health Policy The 2011 GSA Maxwell Pollack Award Lecture” was presented as the 2011 Maxwell A. Pollack Award for Productive Aging lecture on November 16, 2012 at the 65th Annual Scientific Meeting of the Gerontological Society of America, San Diego, California.

hearing on elder abuse: “Justice for All: Ending Elder Abuse, Neglect and Exploitation.” Based on the Government Accountability Office report (Government Accountability Office, 2011), victims and experts highlighted the lack of research, education, training, and prevention strategies. On June 14, 2012, World Elder Abuse Awareness day was held in the White House and President Obama proclaimed its importance and the needs to advance the field of elder abuse (US White House, 2012). In April 2013, Institute of Medicine (IOM) held a 2-day workshop dedicated to elder abuse prevention. However, despite these national efforts, vast gaps remain.

It is estimated that national elder-abuse-related spending in 2009 included \$1.1 million by National Institutes of Health (NIH), \$50,000 by the Centers for Disease Control and Prevention (CDC), \$5.9 million by the Administration on Community Living (ACL), \$0.75 million by the Department of Justice Civic Division, and \$1.2 million by the National Institute of Justice; the Office of Victims of Crimes and the Office on Violence Against Women spent \$520,000 and \$4.9 million, respectively. In 2009, these federal agencies spent a total of \$11.9 million for all activities related to elder abuse, which is dwarfed by the annual funding for violence against women programs (\$649 million). Despite the services provided by these seven federal agencies, many older adults continue to experience abuse, neglect, and exploitation.

In this paper, I highlight the epidemiology of elder abuse in terms of the prevalence, risk factors, and adverse health outcomes. In addition, I discuss key practical issues when dealing with elder abuse cases. Moreover, I describe key provisions of two relevant federal legislations: The Older Americans Act (OAA) and the Elder Justice Act (EJA). Furthermore, I highlight major research gaps and future research directions for the field of elder abuse.

Epidemiology of Elder Abuse

Scope of Elder Abuse

According to the World Health Organization, the prevalence of elder abuse ranged widely from 1% to 35%, depending on the populations, settings, definitions, and research methods. Recent national estimates show that at least 1 in 10 older adults suffers some form of elder abuse, and many in repeated forms (Government Accountability

Office, 2011). At the same time, only a small fraction of elder abuse is reported to the Adult Protective Services (APS). The U.S. National Elder Mistreatment Study, conducted with a representative sample of 5,777 adults aged 60 years and older, reports that approximately more than 10% of community-dwelling elderly adults experienced abuse or potential neglect in the past year (Acierno et al., 2010).

Elder self-neglect is often thought as a separate entity as opposed to elder abuse perpetrated by others. APS data suggest that self-neglect is on the rise and is more common than all of the other forms of elder abuse combined. Recent studies in a large-population-based study indicate that prevalence of elder self-neglect is about 9% (Dong, Simon, Mosqueda, & Evans, 2012), although the extent of overlap between self-neglect and other forms of elder abuse is unclear. However, no population-based epidemiological study has systematically examined the incidence of elder self-neglect or the potential change in self-neglecting behaviors over time.

Despite the increasingly diverse aging population, we have little knowledge on the racial/ethnic differences on the issues of elder abuse. Evidence suggests that prevalence of financial exploitation is almost three times higher and psychological abuse is two times higher in African American older adults than white older adults (Beach, Schulz, Castle, & Rosen, 2010). A recent study in a low-income Latino community indicates that 40% of older adults have experienced abuse in the last year, yet only 2% were reported to authorities (DeLiema, Gassoumis, Homeier, & Wilber, 2012). In the Chinese population, despite the high cultural expectations of filial piety from older adults, 35% Chinese older adults have self-reported elder abuse (Dong, Simon, & Gorbien, 2007). Understanding cultural-specific issues on the definitions, perceptions, and factors associated with elder abuse will be critical to the future design of prevention and intervention strategies in the cultural-specific context.

Factors Associated With Elder Abuse

Sociodemographic Characteristics.—Previous research has documented inconsistent results on the possible association between sociodemographic characteristics and the occurrence of elder abuse. A telephone survey with 82 community-dwelling caregivers reports that younger demented

patients have a higher possibility of suffering from verbal abuse (Cooney, Howard, & Lawlor, 2006). In contrast, other studies have not found any difference in terms of age and sex between elder abuse victims and nonvictims. Different research methodology and population settings may account for the inconsistency of findings. Available evidence suggests that those older than 75 years, African Americans, and those with lower socioeconomic status are associated with elder abuse (Laumann, Leitsch, & Waite, 2008).

Physical and Cognitive Function.—At the individual level, cognitive and physical function impairment have been associated with increased risk for elder abuse. In a population-based study of 238 community-dwelling older adults with elder abuse experience, Dong, Simon, Rajan, and Evans (2011) found that lower global cognitive function level, Mini-Mental State Examination (MMSE), episodic memory, and perceptual speeds are associated with increased risks of elder abuse. Several cross-sectional studies have found that cognitive impairment and physical disability are associated with increased risk for self-neglect, even after considering sociodemographic and socioeconomic status (Dong, Mendes de Leon, & Evans, 2009; Dong, Wilson, Mendes de Leon, & Evans, 2010).

Few longitudinal studies have examined the factors associated with self-neglect. One study of 2,812 older adults in the Established Populations for Epidemiologic Studies of the Elderly (EPESE) cohort found that greater cognitive impairment and depressive symptoms predict self-neglect reports to APS (Lachs, Berkman, Fulmer, & Horwitz, 1994). A study of 5,519 older adults demonstrated that decline in physical function (both observed physical performance testing and self-reported) and executive function is also associated with elder abuse (Dong, Simon, Beck, & Evans, 2013; Dong, Simon, & Evans, 2012b).

At the family level, certain caregiver–care recipient characteristics have been associated with elder abuse. Caregivers for demented patients with lower levels of physical functioning are more likely to report engaging in abuse (Coyle, Reichman, & Berbig, 1993). Agitation and aggression are among the most common and problematic symptoms occurring with dementia. More than half of the demented patients exhibit occasional aggressive behaviors (Homer & Gilleard, 1990). Another study with a convenience sample of 129

caregiver–care recipient dyads also reveals that patients who direct the physical assault and aggression behaviors toward their caregivers are more likely to be victimized by elder abuse (Wiglesworth et al., 2010).

Psychosocial Well-being.—In recent years, research studies and clinical cases have begun to document the associations between elder abuse and psychosocial distress (Comijs, Penninx, Knipscheer, & van Tilburg, 1999; Luo & Waite, 2011). Older adults with depression and signs of anxiety had higher risks of elder abuse (Cooper et al., 2006; Dong, Simon, Odwazny, & Gorbien, 2008; Fulmer et al., 2005). In a community-based cohort, depression was significantly associated with elder abuse cases reported to APS (Lachs, Williams, O'Brien, Hurst, & Horwitz, 1997). Loneliness was associated with increased risk of elder abuse (Dong, Simon, Gorbien, Percak, & Golden, 2007). In addition, the association between psychosocial distress and elder abuse was affected by sociodemographic characteristics. A study on urban Chinese population found that among older adults with depressive distress, those who were older and had lower education levels may have increased risk of elder abuse (Dong, Beck, & Simon, 2010). Demented female patients were reported to be more likely to have a higher risk of experiencing neglect (Natan, Lowenstein, & Eisikovits, 2010). Recent studies suggest that older adults with higher levels of psychological distress and lower levels of social relations are more likely to be reported to APS (Dong, Beck, & Evans, 2010).

Outcomes Associated With Elder Abuse

Despite major gaps in our current knowledge, available evidence suggests that elder abuse is associated with significant adverse health outcomes. One cohort found that self-neglect was associated with an increased risk for all-cause mortality (Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998). Similarly, a study of 9,318 older adults found that self-neglect was associated with a higher mortality rate, particularly during the first year of being identified (Dong, Simon, et al., 2009). In addition, self-neglect is associated with 15 times increased risk for cancer-related mortality and 10 times increase in nutritional- and endocrine-related mortality. Moreover, research from the same cohort suggests that self-neglecting black older adults had substantially higher all-cause mortality

risk, compared with white older adults, and this mortality differential is sustained over time (Dong, Simon, Rajan, et al., 2011).

Previous studies have shown that elder abuse is associated with psychosocial distress. Abused older adults were more likely to report higher level of depression, anxiety, and posttraumatic stress disorder (Yan & Tang, 2001). The level of psychological distress differs by the frequency and types of abuse and violence (Baker et al., 2009; Begle et al., 2011). In addition, older women experiencing psychological abuse repeatedly or multiple types of elder abuse were more likely to present depression or anxiety (Higgins & Follette, 2002). Emotional abuse is also significantly associated with higher levels of psychological distress than physical abuse (Pico-Alfonso et al., 2006).

Evidence suggests that elder abuse is associated with emergency room visits, hospitalization, and nursing home placement and premature mortality. Dong, Simon, and Evans (2012a) found in the Chicago Health and Aging Project (CHAP) cohort that older adults who self-neglect use emergency services three times greater rate than those without self-neglect. In addition, self-neglect is associated with increased rate of hospitalization and longer length of hospital stay (Dong, 2013; Dong, Simon, & Evans, 2012c). Moreover, recent study suggests that self-neglector uses hospice services more frequently and that they have a shorter time between admission and death (Dong & Simon, in press).

Management Principles

Although there are no uniformly agreed management principles for elder abuse, health care professionals could play important roles in the screen, reporting, intervention, and prevention strategies. Despite the complexities of reporting requirement for elder abuse, decision-making capacity is the cornerstone assessment for any cases of elder abuse while balancing the ethical principles of autonomy, beneficent, and paternalism. Interdisciplinary teams (health care professionals, APS workers, legal professionals, etc.) should work collectively to ameliorate abusive situations and restore health and well-being in this vulnerable population.

The Role of the Health Care Professional

Health care professionals are well situated to screen for elder abuse and detect vulnerabilities.

During a routine physician office visit, answers to questions about how older adults manage their daily lives can suggest predisposing issues that will eventually impair the patient's ability to live independently. Assessments of the patient's functional and cognitive status are important adjuncts to understanding the predisposing and precipitating risk factors associated with elder abuse. In addition, those with the presence of psychosocial distress could also be potentially screened for elder abuse.

Given our recent understanding that elder abuse often interacts with the health care systems, increased screening and treatment should be instituted in the emergency departments and hospital settings. Discharge planning and home health services could play pivotal roles in identifying potentially dangerous environment that could jeopardize the safety and well-being of older adults in the community. Early detection and interventions, such as leveraging effective treatment of actual underlying issues, providing community-based services, and appropriately involving family, may help delay or prevent elder abuse. Indicators of possible elder abuse should lead to a report to APS, the ombudsman, or local police.

Reporting

Almost all U.S. states have mandatory reporting legislations that require health care professionals to report a reasonable suspicion of elder abuse cases. APS is charged with taking a report and investigating alleged elder abuse in the community. A long-term care ombudsman agency investigates alleged incidents that occur in licensed facilities such as skilled nursing facilities. A survey of APS workers in 43 states found that of 17 occupational groups, physicians were rated in the least helpful category for detecting abuse and neglect. The reasons physicians cite for not reporting include subtlety of signs, victim denial, and lack of knowledge about reporting procedures. Other reasons include concern about losing physician-patient rapport, doubts about the impact of APS intervention, and perceived contradictions between mandatory reporting and health care provider's ability to act in the patient's best interests.

The wide arrays of social services provided by APS agencies vary due to differences in state laws, how enforcing laws are interpreted, and levels of funding and interest in different areas within the state. Regardless of the locations, APS aims

to provide elder abuse victims with coordinated, interdisciplinary care that encompasses social and health systems. Services are delivered with an underlying philosophy that promotes a client's rights to autonomy and self-determination, maintains a family unit whenever possible, and provides recommendations for the least restrictive living situation. The APS worker must presume the client has decision-making capacity and must accept the client's choices until the client is determined to lack capacity by a health care provider or the legal system.

Decision-Making Capacity

One of the most difficult dilemmas is under what types of situations does the medical community and society at-large have a responsibility to override an adult person's wishes? For health care professionals, this issue is typically framed in terms of decision-making capacity, something that clinicians assess on a regular basis in both formal and informal ways (Dong & Gorbien, 2005). The presence or absence of capacity is often a determining factor in what the health care professionals, community, and society needs to do next. However, capacity is not often completely present or completely absent. It is a gradient relationship between the issues in question and older adult's ability to make these decisions. For complicated health issues, there is greater need to require higher levels of decisional capacity. At the same time, for simple issues, even a cognitive impaired adult could have decisional capacity. However, the health care provider is often forced to take a gray area and make it black or white for purposes of guiding next steps such as guardianship/conservatorship. Commonly used brief screening testing such as the MMSE is inadequate for determining capacity except at the extremes of the score. Tests useful in assessing decision-making capacity include the Hopkins Competency Assessment Test (Janofsky, McCarthy, & Folstein, 1992).

The Role of Interdisciplinary Teams

There has been the formation of wide range of interdisciplinary teams in the field of elder abuse despite a dearth of data regarding cost effectiveness is an indicator of the complexity of the problem. Such team is usually comprised of primary care providers, social worker, social services, legal professionals, ethicist, mental health professionals,

community leaders, and residents. However, before such meeting occur, in-home visit should be conducted and would greatly assist the team in the assessment, evaluation, and intervention strategies for elder abuse cases. A survey of the APS workers who made referrals to the team indicated that the team was helpful in confirming abuse, documenting impaired capacity, reviewing medications and medical conditions, facilitating the conservatorship process, persuading the client or family to take action, and supporting the need for law enforcement involvement. Although interdisciplinary teams may be an example of "action over evidence," the team members' belief that these meetings are highly effective implies the utility of this mechanism for handling elder mistreatment and deserves further study.

Key Federal Policies for Elder Abuse

The Older Americans Act

The OAA includes a number of specific provisions (Titles II, III, IV, and VII) that have significant relevance to elder abuse. In Title II, OAA authorizes ACL to delegate a person responsible for elder abuse prevention and services in (a) developing objectives, priorities, and long-term plans for elder justice activities; (b) supporting state elder abuse prevention activities; and (c) supporting research, data collection, and information dissemination. In addition, OAA requires the ACL to establish and operate National Ombudsman Resource Center under the supervision of the Director of the Office of Long-Term Care (LTC) Ombudsman Programs. Title II authorizes ACL to establish and operate the National Center on Elder Abuse to gather research evidence and provide information on elder abuse, to provide technical assistance and training, and to conduct research and demonstration projects.

Title III provisions of the OAA requires states to submit to ACL a state plan for grant eligibility. If a given state desires services for the prevention of elder abuse, the plan must contain assurances that Area Agency on Aging programs would be consistent with relevant state laws and synchronize closely with existing state APS-related activities. In addition, this provision requires the ACL to provide grant funding to states for supportive services that may include services for legal assistance and counseling, LTC ombudsman, prevention of elder abuse, and victim assistance and crime prevention programs.

In Title IV programs, OAA authorizes the ACL to provide grant funding for projects in local communities relating to elder abuse, outreach programs to assist elder abuse victims, extension of access to violence programs across life span, and promotion of research on barriers to providing coordinated and effective services to elder abuse victims. In addition, it requires ACL to provide grant funding to national legal assistance support system. Title IV requires the ACL to offer grant support to eligible entities to establish and operate Resource Centers on Native American Elders and to provide grant funding to conduct demonstration and to evaluate multidisciplinary projects between the state LTC Ombudsman Program, legal assistance agencies, and state protection and advocacy systems for individuals with developmental disabilities and individuals with mental illnesses.

In Title VII programs, OAA authorizes the ACL to provide funding to state agencies to establish an Office of the State LTC Ombudsman and State LTC Ombudsman program in order to identify, investigate, and resolve complaints from residents of LTC facilities. In addition, it requires ACL to provide grant funding to state agencies to develop and enhance programs to address elder abuse and to conduct community outreach and education, coordination of state and local services, training of relevant professionals and caregiver workforce, and promotion of state statutes to prevent elder abuse. Moreover, it mandates the state agencies to establish a State Legal Assistance Developer and to provide grant funding to implement vulnerable elder rights protection activities for Native American groups and elder fatality and serious injury review teams. Lastly, it requires ACL to award grants to promote and expand state comprehensive elder justice systems, provide access to information, coordinate multidisciplinary efforts to reduce duplications and gaps in services in the existing systems, and standardize the collection of data relating to elder abuse.

Elder Justice Act

The EJA was passed as a part of the Affordable Healthcare Act and for the first time, the EJA unifies the federal systems to respond to elder abuse through training, services, and demonstration programs. ACL is responsible for the implementation of the EJA as well as formation of the Elder Justice Coordinating Council and the National Advisory Board. More specifically, the Elder

Justice Coordinating Council will be required to issue reports to describe the activities, accomplishments, and challenges faced as well as to provide legislative recommendations to congressional committees.

The EJA will also be responsible for issuing human participants protections guidelines to assist researchers and establishing elder abuse forensic centers. The EJA will provide grants and incentives for long-term care staffing and electronic medical records technology grants programs and will collect and disseminate annual data related to elder abuse from adult protective services. The EJA will also be responsible for sponsoring and supporting trainings, services, reporting, and the evaluation of elder justice programs in community and long-term care settings. Regrettably, compared with the previous EJA from the 109th Congress, key elements were dropped in the current bill, which include but not limited to the national data collection effort, the consumer clearinghouse, and grant programs for prevention, detection, assessment, and treatment of, intervention in, investigation of, and prosecution of elder abuse.

The EJA has authorized \$777 million funding over 4 years, and immediate appropriation is particularly important, as the APS will garner significant funding to bolster their direct services to victims. Recently, a survey in 30 states reported that 60% of APS programs have faced budget cuts on average 14%, whereas two thirds of the APS reported an average increase of 24% in elder abuse reports. A recent letter from the Leadership Council of Aging Organizations ([Leadership Council of Aging Organizations, 2010](#)) strongly urged the Senate and House Subcommittee on Labor, Health and Human Services and Education (HELP) to fully appropriate the EJA. Comprehensive advocacy and policy efforts are needed to push for the issues of elder abuse in these legislations at the local community, city, state, and federal levels ([Dong & Simon, 2011](#)).

Future Research Directions

Population Research

It is imperative that nationally representative longitudinal studies exist to examine the incidence of elder abuse subtypes in diverse settings. Studies need to focus specifically on the risk/protective factors associated with the incident cases, as well as specific estimates of the strength of these

relationships. Longitudinal studies are needed to elucidate cognitive decline and dementia subtypes on the risk for incident elder abuse. For physical function, studies are needed to quantify the causal mechanisms between self-reported physical function and directly observed physical performance testing and the risk for incident elder abuse.

For psychological well-being, it is critical to explore the impact of psychological decline on the risk for elder abuse, as well as the impact of elder abuse on psychological distress and trajectories. Comprehensive assessment of psychological factors is needed on the constructs of depression, anxiety, perceived stress, hopelessness, suicidal ideation, and other clinical psychiatric constructs. For social well-being, research is needed to examine the temporal relations between social network, social support, loneliness, and social participation in relations to elder abuse. Social network analyses will be important tools to elucidate the network size, density, and quality in relation to the risk for elder abuse.

Longitudinal research is also needed to understand the potential perpetrators' characteristics, relations, settings, and contexts with respect to elder abuse victims. The fields of child abuse and domestic violence have demonstrated feasibility of conducting research on potential perpetrator(s), and we need to continue pushing for innovative methods to understand the potential perpetrators' perspectives. This data will have direct relevance on the design and conduct of prevention and intervention studies.

Research is needed to understand the consequences associated with specific subtypes of elder abuse. Research is needed to explore the risk, rate, and intensity of these health services utilizations with respect to elder abuse. Economic analyses are needed to examine the costs associated with elder abuse, specific subtypes, and intervention programs. As many cost-benefit analyses are biased toward older adults, innovative strategies are needed to capture the wide range of personal, community, financial, and societal costs of elder abuse.

Leverage Existing Longitudinal Studies

Nationally representative cohort focused on the issues of elder abuse will likely be time consuming and costly to obtain. The field of elder abuse needs to continue working closely with existing longitudinal aging studies to add elder-abuse questions into these cohorts. These longitudinal studies may include the Health and Retirement

Study (HRS), National Social Health Aging Project (NSHAP), EPESE, Cardiovascular Health Study (CHS), National Health Aging Trends Study (NHATS), and many others. However, it is unlikely to be sufficient for individual investigators to singularly approach these studies for cooperation. There are also methodological complexities and issues within these longitudinal studies that will make synchronization of data collection and funding very difficult. Coordinated efforts are needed from a collective body of researchers and practitioners, but particularly from federal and private funding agencies and important stakeholders.

The field of elder abuse should continue to push for linkage of data sets between existing cohorts and administrative APS data sets. Prior experiences with the New Haven EPESE and CHAP studies have demonstrated feasibility and success in understanding the issues of elder abuse. In addition, these data linkages have contributed greatly to the knowledge base about the cross-sectional as well as longitudinal risk factors associated with elder abuse. Moreover, this approach has provided pivotal answers on the adverse health outcomes associated with elder abuse, which has served as firm foundation to push for practice and policy changes at the national level.

Unification and Standardization of APS Databases

Even though the data collection variations in individual states, the core common elements are needed to be uniformly collected across all states. It will be important to follow these APS cases over time with respect to specific encounters with health care, social services, legal, and criminal justice systems. Furthermore, unified national APS data collection could be invaluable to evaluate the needs, process, and outcomes of APS programs and interventions at the individual client's level; evaluate the current models of multidisciplinary team; evaluate the effectiveness of current training programs; and explore the context of the barriers for APS staff in their daily work. Multidisciplinary collaborations are needed to involve APS, clinicians, social workers, legal professionals, institutional research board, and other relevant disciplines.

Interventions

Systematic reviews of literature suggest that there is a great gap in our knowledge about the

evidence-based prevention and intervention strategies to assist the victims of elder abuse (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009). Although multidisciplinary team approaches and multicomponent interventions appear to be the best approach, more systematic studies are needed. Rigorously designed intervention studies and measures of relevant outcomes to elder abuse are needed. In addition, prevention strategies are critically needed. Systematic examinations of the longitudinal risk/protective factors as well as effect size are needed to devise targeted prevention studies. Given the extent of the different types of elder abuse and variation in risk/protective factors and perpetrator characteristics, intervention and prevention studies should begin to focus within the specific dyads, which may be at particularly high risk for elder abuse. Prevention and intervention studies must consider the cost effectiveness as well as the potential for scalability at the city, state, or national levels.

Cultural Issues

With the increasingly diverse U.S. and global aging population, we must set national priorities to better understand the cultural issues related to elder abuse in different racial/ethnic populations (Dong, Chang, Wong, Wong, & Simon, 2011). In 2010, approximately 20% of people aged 65 and older were minorities, with 8.4% were African American, 6.9% were of Hispanic origin, 3.5% were Asian or Pacific Islander, and 1% were American Indian or Native Alaskan (Administration on Aging, 2012). From 2010 U.S. census, minority populations are growing rapidly. In the last decade, the rate of growth has been 5.7% in the whites, 43.0% in the Hispanics, 43.3% in the Asians, 18.3% in the Native Americans, and 12.3% in the African Americans. Quantitative and qualitative studies are needed to better define the concept and cultural variations in the construct and definition of elder abuse and its subtypes. Moreover, studies are needed to understand the prevalence, incidence, risk/protective factors, and consequences associated with elder abuse and its subtypes in these populations.

Significant challenges exist in the preparation and conduct of aging research in minority communities, especially regarding culturally sensitive issues such as elder abuse. The community-based participatory research (CBPR) approach could be a potential model to explore the issues of elder

abuse in these communities. CBPR necessitates equal partnership between academic institutions with community organizations and key stakeholders to examine the relevant issues. This partnership requires reciprocal transfer of expertise and needs to build infrastructure toward sustainability. Recent elder abuse research in the Chicago Chinese community has demonstrated success and has enhanced infrastructure and networks for community engaged research and community-academic partnerships. CBPR could be a novel model for conducting systematic and culturally appropriate research in minority populations.

Interdisciplinary efforts are needed to promote elder abuse awareness in a culturally appropriate way at the community, state, and national levels (Dong, Simon, Fulmer, et al., 2011).

The PINE (Population Study of Chinese Elderly) 華人松年研究 is one example of fruitful collaboration between academic and community, leveraging the principles of CBPR to advance the scientific knowledge of elder abuse, filial piety, and psychological distress in Chinese populations. We instituted a community advisory board of key stakeholders to guide our ongoing collaborations and initiated a grassroots educational initiative on health and psychosocial distress facing the Chinese population. The PINE study is a population-based epidemiological study of 3,159 Chinese older adults in the greater Chicago area. With strong community support and our bicultural/bilingual research team, 91% of eligible Chinese older adults have agreed to participate in our in-depth survey interviews. In addition, through the integration of grassroots civic engagement with culturally appropriate activities (i.e., calligraphy, Tai-chi, Chinese poetry, water painting, etc.), Chinese older adults have been more willing to discuss and disclose family conflict and elder abuse in research studies.

Needs for Increased Funding and Investigators

Compared with the field of child abuse and domestic violence, funding for elder abuse is extremely low. It is important for NIH intramural and extramural programs to consider elder abuse as a strategic priority in the coming years. It is equally important for NIH, Agency for Healthcare Research & Quality (AHRQ), national Science Foundation (NSF), Patient Centered Outcomes Research Institute (PCORI), and other relevant public and private funding agencies to consider dedicated Request for Funding Announcement

(RFAs) to attract researchers from other fields. This is especially important, as there is no research expert currently sitting on any of the standing Center for Scientific Review (CSR) panels. Without the presence of knowledgeable NIH grant reviewers, the field of elder abuse is in great jeopardy.

We need to continue expanding the research workforce to conduct sound scientific research to advance the field of elder abuse. There are multiple barriers for investigators to carve out a career path dedicated to elder abuse. Lack of protected time, lack of existing data, human participant issues, access to elder abuse victims, and lack of NIH-dedicated mechanisms are often cited as barriers. Junior investigators could continue applying for the traditional K-mechanisms as well as other career development pathways (e.g., Paul Beeson Award, Doris Duke Award, RWJ Awards, etc.). Following the model for child abuse and domestic violence, the NIH and other funding agencies could institute novel career development mechanisms to build interdisciplinary research careers in elder abuse.

Conclusion

In this Maxwell Pollack Award in Aging lecture, this paper highlights the epidemiology of elder abuse as well as the complexities in research, practice, and policy. Nationally representative longitudinal research is needed to better define the incident, risk/protective factors, and consequences of elder abuse in diverse racial/ethnic populations. Systematic education and training are critically needed across all relevant fields. Comprehensive efforts are needed to continue attracting scientific investigators in multiple disciplines. The EJA represents the first federal legislation dedicated to combating elder abuse and its full appropriation is critically needed. Although there remain vast gaps in the field of elder abuse, unified and coordinated effort at the national level must continue in order to preserve and protect human rights of a vulnerable and diverse aging population (Dong, Simon, Fulmer, et al., 2011).

Funding

Dr. Dong is supported by the American Political Sciences Association (APSA) Congressional Policy Fellowship/Health and Aging Policy Fellowship and National Institutes of Health grants (R01MD006173, R01AG042318, R01CA163830, R21AG038815, and R01 AG11101), American Recovery and Reinvestment Act (ARRA) (RC4 AG039085), Paul B. Beeson Award in Aging (K23 AG030944), The Starr Foundation, John A. Hartford Foundation and The Atlantic Philanthropies. Dr. Dong reports no conflict of interest and declares no financial interest.

Acknowledgments

The author wishes to thank the front line workers combating the issues of elder abuse and neglect and protecting this extremely vulnerable population. Dr. Dong was responsible for the conception and design and was involved in the drafting of the manuscript and critical revision of the manuscript.

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