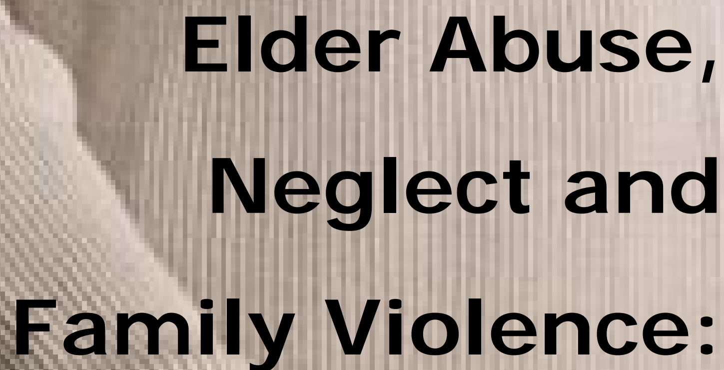

Elder Abuse, Neglect and Family Violence:

A Guide for Health Care Professionals

Wisconsin Coalition Against Domestic Violence

in collaboration with the

Wisconsin Bureau of Aging and Disability Resources

Revised 2009

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Social Change Through Action and Advocacy

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Statement of Support from the Wisconsin Medical Society (2009)

The Wisconsin Medical Society appreciates the opportunity to review and comment on this booklet and applauds the efforts of the Wisconsin Coalition Against Domestic Violence and the Wisconsin Bureau of Aging and Disability Resources on developing a superb resource manual. The Wisconsin Medical Society endorses the booklet and encourages health care professionals around the state to use it and incorporate the many suggestions into their everyday practices. Physicians and other health care professionals can make a tremendous impact on the lives of victims of family abuse. Through awareness of the problem, and appropriate identification and treatment of abuse, health care professionals can help stop the cycle of family violence in the lives of many individuals.

Introduction

Approximately 75% of the cases of elder abuse, neglect and exploitation reported to county lead elder abuse agencies is by **family members** *(Wisconsin Bureau of Aging and Disability Resources, 2006).* This guide will provide you and other health care professionals with information, interventions and resources for situations involving family violence in later life. Other forms of elder abuse such as self-neglect or abuse by strangers also affect older people. Health care professionals should screen for all types of abuse. This booklet will deal specifically with identifying and helping older persons abused by family members (spouse/partner, adult children/grandchildren, siblings, and/or other family members). Many interventions discussed here may also be appropriate for other forms of elder abuse such as self-neglect and abuse by strangers.

An elderly woman was discussing with her doctor how difficult it was to take care of her husband after his stroke. Rather than asking what was difficult, other physicians had told her that this is not unusual and she should try harder to cope. When screened for domestic abuse, the intervening physician found that her husband would not allow her to adjust the thermostat, open a window, or make any noise. If she did, she was subjected to his verbal abuse and threats. This was not new behavior. She was struggling to provide increased care to someone who had battered her for years.

***NOTE**: The majority of victims of elder abuse, neglect and violence are female. (Wisconsin Bureau of Aging and Disability Resources, 2006) Thus, the pronouns and examples in this booklet reflect that fact.*

As a health care professional, you are in a unique position to identify elder abuse and domestic violence. During physical examinations, you may find suspicious injuries and bruises or symptoms of stress such as chronic depression, anxiety or chest pains. Victims are more likely to feel comfortable disclosing abuse to you, their trusted health care provider, than to other individuals in their lives. While you are not expected to "fix" or solve elder abuse, you do have an opportunity to ask screening questions about family violence, listen to the patient and acknowledge her story, help break the patient's isolation, offer support, talk about safety and connect the patient with local resources.

After decades of abuse, a woman in her mid-70's who had suffered four decades of physical, financial and emotional abuse by her husband decided to disclose the abuse to her physician. He immediately connected her to the health care facility's social worker who put her in touch with a local program for older battered women. Yet her clinical depression continues, despite her husband's death. She says, "I am so numb. I have no tears left inside."

Everyone benefits from screening for family violence. Every patient who is **female, over age 60 or has a disability** should be asked about safety in their on-going relationships at home or in facilities where they reside. For some victims, a health care provider may be the only professional contact and opportunity they have to disclose fears and seek help to break the isolation often associated with abuse. Screening may also provide a chance for early detection of the root causes of physical and/or emotional symptoms so health care providers can offer better care by understanding the patient's life context. Failure to identify family violence results in treating multiple symptoms and illnesses and offering treatment that may be inappropriate or potentially dangerous. For example, prescribing tranquilizers for stress to a victim of domestic abuse could cloud the patient's ability to respond quickly in a life-threatening situation. Early identification can prevent a patient from needless physical and emotional suffering.

Historically, health care professionals have identified very few older victims for referral to services that offer the safety planning and support they need. Many health care workers do not routinely ask about family abuse. Too often, bruises on older people are dismissed by health care providers as due to "a fall," "clumsiness," or "poor diet." Others may only ask younger women about potential abuse. Providers may label victims who hint at problems at home as "unstable," "unappreciative," or "demented" because the providers are not identifying the underlying cause of their symptoms.

This booklet defines elder abuse, including domestic violence in later life, and lists common signs and symptoms, answers frequently asked questions, and identifies interventions. Potential referrals are in the **Resources** section, starting on page 31.

> **"Before I left him, I had no time for friendships. I had to wait on him hand and foot. He swore at me for anything not perfect in the meal or if I looked at him the wrong way. He has some impairments but he could do a lot for himself. He says he's strong enough to put my head in the toilet. He said it would be so easy to kill me. I packed my bag and went to the shelter. Now I'm free and see people all the time."**
>
> **-88 year-old woman describing 88 year-old husband**

What is Elder Abuse?

Under Wisconsin law, an "elder adult at risk" is a person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, financial exploitation, neglect or self-neglect.

(1) <u>Abuse</u> has five sub-categories:

"Physical abuse" is the "intentional or reckless infliction of bodily harm." Signs include:

- Fractures
- Welts
- Lacerations
- Punctures
- Burns (unusual location, type, or shape similar to an object such as an iron or cigarette burn)
- Bruises (presence of old and new, shape similar to an object like a belt or fingers, bilateral on upper arms from holding or shaking, clustered on trunk from repeated shaking)
- Bite marks

“Emotional abuse” is “language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.” Signs include:

- Confusion
- Excessive fears
- Insomnia, sleep deprivation, or need for excessive sleep
- Change in appetite
- Unusual weight gain or loss
- Loss of interest in self, activities or environment
- Ambivalence
- Resignation
- Withdrawal
- Agitation
- Anxiety or panic attacks
- Tranquilizer or sedative use
- Suicidal ideation or attempts

“Sexual abuse” is a violation of Wisconsin’s criminal sexual assault law. Signs include:

- Torn, stained or bloody underclothing
- Difficulty in walking or sitting
- Pain, itching, bruising, or bleeding in genital area
- Unexplained venereal disease or genital infections

“Unreasonable confinement or restraint” includes the intentional and unreasonable confinement in a locked room, involuntary separation from his or her living area, use of a physical restraining device or the administration of unnecessary or excessive medication to an individual, unless the methods or devices are used in Wisconsin-regulated entities in compliance with state or federal law. Signs include:

- Locked in a bedroom or closet
- Tied to a chair or bed
- Left on a toilet, in bed, on a chair when known that the elder can’t ambulate or transfer on own
- Overmedicated

“Treatment without consent” is the administration of medication or certain mental health surgeries or research without proper informed consent or lawful authority.

(2) Financial Exploitation is obtaining an elder's money or property by deceiving or enticing the individual, or by forcing, compelling, or coercing the individual to give, sell at less than fair market value, or in other ways convey money or property against his or her will without his or her informed consent. It also includes criminal "theft," the substantial failure or neglect of a fiscal agent (such as a guardian, agent under a financial power of attorney or trustee) to fulfill his or her responsibilities, forgery, credit card crimes, identity theft and related financial actions. Signs include:

- Inaccurate, confused, or no knowledge of finances
- Unexplained or sudden inability to pay bills, purchase food or personal care items
- Disparity between income/assets and lifestyle
- Fear or anxiety when discussing finances
- Unprecedented transfer of assets from an older person to other(s)
- Unwillingness to spend money on an elder for needed services or care when the elder can afford to pay for them
- Extraordinary interest by family member in older person's assets

An alcoholic son forces his 89 year-old father to turn over his monthly Social Security check. When the father refuses, the son ties him to a chair so he cannot leave the house.

(3) Neglect is the failure of a caregiver to secure or maintain adequate care, services, or supervision for an elder, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the elder's physical or mental health.

(4) Self-neglect is a significant danger to an individual's physical or mental health because the individual is responsible for his or her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care. Signs of both neglect and self-neglect include:

- Dehydration
- Malnutrition
- Hypo/Hyperthermia
- Excessive dirt or odor
- Inadequate or inappropriate clothing
- Absence of eyeglasses, hearing aids, dentures or prostheses
- Unexpected or unexplained deterioration of health
- Decubitus ulcers ("bedsores")
- Signs of excess drugging, lack of medication or other misuse (e.g., decreased alertness, responsiveness and orientation)

Family members may use a variety of tactics to abuse older persons such as physical, financial, sexual or emotional abuse. Often abusers engage in several of these forms of abuse together.

Other indicators of abuse by family members

The patient may:

- Express or present a sense of isolation — no access to money, friends, family, job, transportation, church, etc.
- Have repeated "accidental" injuries that are suspicious
- Visit a number of doctors so no one has an accurate record of injuries ("doctor hopping")
- Visit health care facilities for vague complaints or acute anxiety with no reported injuries or have psychiatric hospitalizations for anxiety or depression
- Avoid seeking medical attention for injuries until days or weeks after injury occurred
- Refer to a family member's "anger" or "temper"
- Flee frequently from home
- Consider or attempt suicide
- Have a history of alcohol or drug abuse
- Minimize injuries
- Exhibit severe depression
- Be unable to follow through with medical care due to abuser's control or missed appointments
- Present as a "difficult patient"

"I couldn't ever get away from him a whole day because I needed to give him insulin injections. My kids didn't want to be around because he's so nasty and he chased all my friends away. Finally, he got so bad he had to go to a nursing home. Now I'm free to see people again."

-81 year-old woman describing 84 year-old husband

The suspected abuser may:

- Be verbally abusive in public to the patient or health care staff
- Attempt to convince health care providers that the patient is incompetent or insane
- Be overly attentive
- Control most of a patient's daily activities
- Be overly protective or controlling of a family member (e.g., refuses to leave the room during exam or treatment)
- Be overly charming and friendly to health care providers

[Institute for Clinical Systems Integration (1996); Domestic Violence Project (1994)]

What is domestic abuse in later life?

How are older individuals harmed?

Older individuals are harmed in various ways, such as accidents. In some cases, well-intended caregivers attempt to provide care but are unable to do so. In other situations, a person with an organic condition, such as Alzheimer's disease, is unable to control his or her behavior and becomes aggressive or sexually inappropriate. An older individual may be harmed as a result. Finally, abuse, neglect and financial exploitation can cause fear and physical injury.

A significant portion of abuse in later life is family violence.

When the harm is caused by abuse, the offender usually has an ongoing relationship with an expectation of trust with the older victim. Studies have found that a significant portion of elder abuse is spousal abuse, often occurring over many years. (Pillemer and Finklehor, 1989; Podnieks, 1992; Wisconsin Bureau of Aging and Disability Resources, 2006) Evidence also shows that many abusers are not caregivers; instead, they are often family members who are financially and/or emotionally dependent on their victims. (Pillemor and Finklehor, 1988; Podnieks, 1992; Brandl and Horan, 2002; National Association of Adult Protective Services Associations [NAPSA], 2003; Otto and Quinn, NAPSA, 2007)

"He wouldn't pay for any of my medicine or doctors. He said I didn't really need it and it was too expensive. He didn't even visit me after surgery. I'll have a bit of a pension but how will I survive? I'll figure out a way through. Better to live on a little than live with his hatred and indifference."

-68 year-old woman who successfully got free from 78 year-old partner

Family members who abuse older victims operate from a variety of assumptions.

Early research suggested that elder abuse was primarily due to "caregiver abuse" and was a result of an overburdened caregiver hurting a frail, dependent, elderly person. (Pillemer and Finkelhor, 1988) More recent research does not support this theory. (Wolf, Generations 2000; Otto and Quinn, NAPSA, 2007) In cases where the caregiver indeed finds care giving stressful, the caregiver engages in behaviors that are self-destructive rather than abusive. For example, some caregivers overeat, abuse substances, smoke, do not get adequate sleep or do not exercise when feeling overwhelmed by their life circumstances and role as a caregiver. These behaviors are examples of caregiver distress.

In contrast, abusers operate from a belief system in which they are entitled to use power and control tactics to get their way and punish or dominate their victims. These tactics can be used in cases of physical, sexual, or emotional abuse, neglect or financial exploitation.

"As a doctor, what I say or don't say carries a lot of weight. What seems to be the most helpful and successful intervention is breaking the isolation. Having more people in the patient's life leads to broader perspectives. This can result in less crazy-making for the patient and the family."

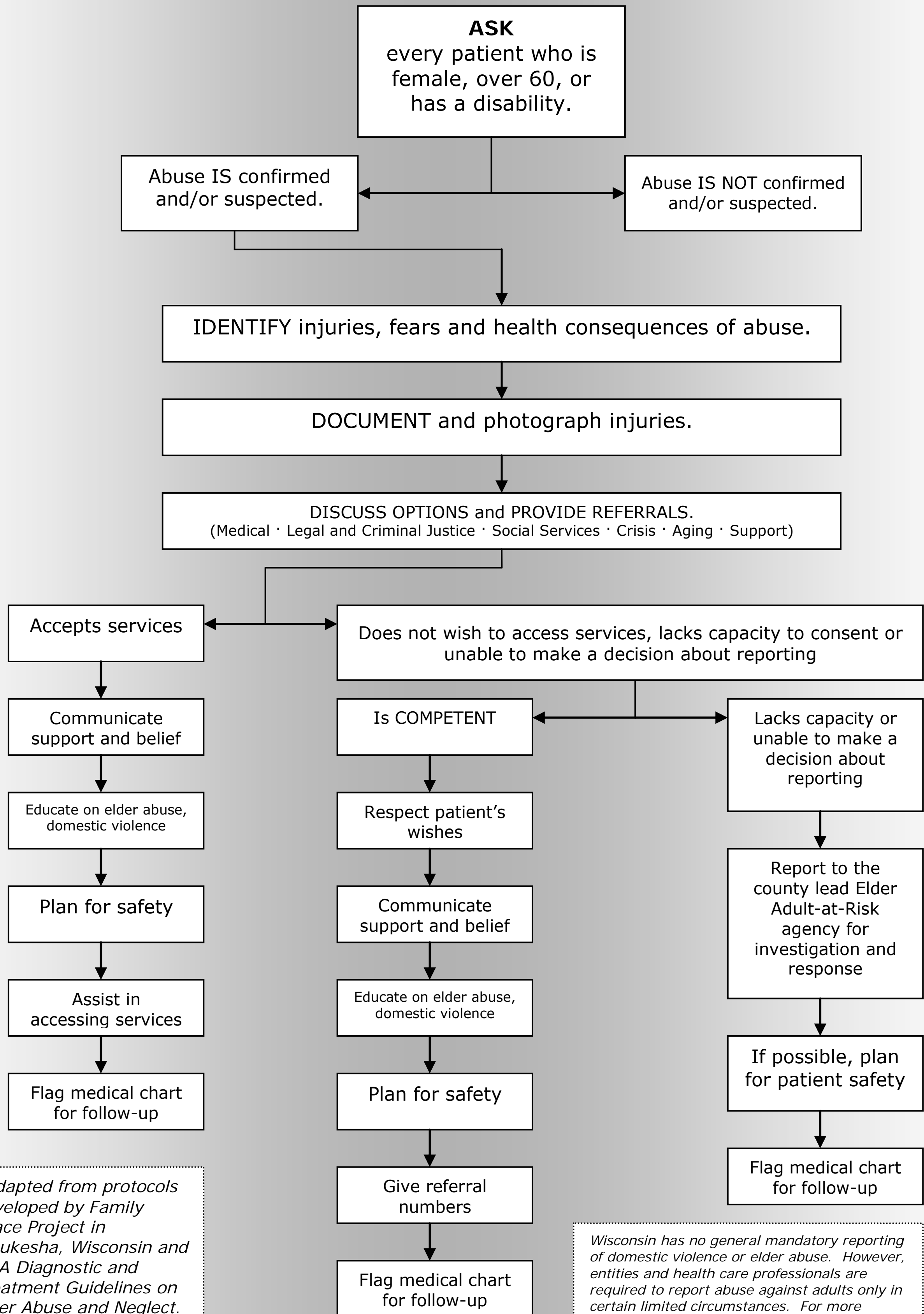
-Dr. Kevin Fullin

Domestic abuse is defined as "a pattern of coercive control that one person exercises over another." (Schechter, 1987) Battering behavior physically harms, arouses fear, and prevents victims from doing what they wish or forces them to behave in ways they do not want. (Schechter, 1987) Often the abusers "purposefully inflict pain and suffering and may abuse their victims in deliberate and extensive ways." (Ramsey-Klawsnik, 1995) Some abusers are simply interested in stealing money and possessions from family members to meet their personal needs.

Too often professionals focus on abuser issues that may co-exist with elder abuse, such as substance abuse, mental illness or caregiver distress, rather than recognizing power and control dynamics that are prevalent in many cases. The caregiver stress model can blame the victim and lead to remedies that may further endanger the patient. (Brandl and Raymond, 1996; Otto and Quinn, NAPSA, 2007) These professionals generally refer "stressed caregivers" to social service agencies for help and focus on the needs of the abuser. Unfortunately, these professionals generally do not consider domestic violence interventions for victims (such as support groups, safety planning, restraining orders, and emergency shelters) or criminal justice actions against the abusers. (Pillemer and Finkelhor, 1988; Breckman and Adelman, 1988; Podnieks, 1992; Vinton, 1991; Harris, 1996)

No foolproof, prescriptive formula exists to determine who is a batterer and who is an abusive caregiver or family member. **Since victims are harmed no matter what assumptions or set of circumstances abusers are operating from, professionals should pursue intervention strategies that focus on safety and support for victims.** (Brandl and Raymond, 1997) Keep in mind that many abusers lie, justify their actions and attempt to manipulate professionals. (Bancroft, 2002) Listen to the victim's account of the incident and/or injuries. Evaluate whether the medical evidence supports the version of events being described by the abuser.

Protocols for Domestic Abuse*



**Adapted from protocols developed by Family Peace Project in Waukesha, Wisconsin and AMA Diagnostic and Treatment Guidelines on Elder Abuse and Neglect.*

Wisconsin has no general mandatory reporting of domestic violence or elder abuse. However, entities and health care professionals are required to report abuse against adults only in certain limited circumstances. For more information on reporting considerations and procedures, see p. 22.

What can health care providers do?

Health care providers can and should ask about family abuse, identify injuries and the patient's needs, and document injuries or statements. You can discuss options and provide information about family abuse to victims and provide information about local resources. If the victim consents, you may make referrals to local agencies and, in certain limited circumstances, you will need to report the abuse to law enforcement or a county's elder abuse agency. (See http://dhs.wisconsin.gov/aps/contacts/eaaragencies.htm.)

The goals in asking about abuse and responding are to:

- help a victim understand that abuse is not the victim's fault and that only the abuser is responsible for the behavior
- let the victim know that the health care setting is a safe place to discuss the situation
- leave the door open, so that the victim can discuss the situation whenever ready to do so
- promote safety
- break the victim's isolation
- support the victim in regaining control of his or her life

The optimal outcome is the development of safety interventions for victims of abuse.

ASK, LISTEN and SUPPORT

Health care providers should ask every patient who is female, over age 60 or has a disability about safety in relationships in the home.

You should include screening for domestic abuse as part of the initial assessment and routine visits. By doing so, you may identify safety factors affecting the health of the patient. Furthermore, you can provide information on community resources that may assist your patient.

> **"A great question that health care providers can ask older women in screening for domestic violence is 'Are you getting out with your friends?'"**
>
> **-Dr. Kevin Fullin**

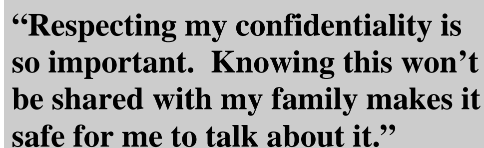
How to Ask about Abuse

Asking a patient about family violence may not be easy at first. Nevertheless, as practitioners, you often must ask personal questions and learn to do so in a straightforward and sensitive manner, without causing or experiencing embarrassment. Unless the patient seems eager to discuss the abuse, inquire by asking general questions about home life and relationships. Do not be afraid to ask; research shows that victims of family violence generally will answer sensitive questions from a concerned and informed professional. Ask on every visit; many victims need considerable encouragement over time to build the trust needed to confide in their health care professional. Providers will generally ask victims about family violence many times before

the victim feels comfortable enough to disclose. Whether or not a victim discloses has much to do with a victim's sense that, as the provider, you are ready to hear the response. (Worcester, 1992)

Universal screening, (i.e., inquiring of every patient) has many benefits. It demonstrates that you are not singling out a particular patient based on certain stereotypes of what a victim of domestic violence looks like. It shows that you are a health care professional who understands the impact abuse can have on a patient's health and it leaves the door open if the victim is not ready to disclose on this visit. Patients who aren't experiencing family abuse are often glad their health care provider is asking and many times know someone who is a victim, for whom the information you provide will be helpful. (Zink et al., 2004; AWARE program, 1995; Brandt, Hadley, Holtz, 1996; Domestic Violence Project, 1994)

A handy pocket card for screening is available on WCADV's website at: www.wcadv.org. Click on "Health Care" and then "Resources" or send a self-addressed, stamped envelope to WCADV. See **Wisconsin Resources / Wisconsin Coalition Against Domestic Violence**, pages 32-33.



"Respecting my confidentiality is so important. Knowing this won't be shared with my family makes it safe for me to talk about it."

-Quote from older abused woman

Health care providers are also responsible for ensuring confidentiality so that they do not put patients at risk. You should conduct abuse screening with only you and the patient present, unless the patient requests an advocate or interpreter. The suspected abuser must not be present. If necessary, use your "health care professional authority" to creatively move out of the room a suspected abuser or anyone else who accompanies the patient so that the patient has the opportunity to talk freely and confidentially without fear of retribution. Have a reliable interpreter available for non-English speaking or hearing-impaired patients. Never ask a family member to serve as an interpreter when screening for abuse. Make sure that other patients and health care providers uninvolved with the case are not included or able to overhear the discussion.

Arrange the patient's chart (including electronic) so that neither the abuser nor other unauthorized persons have access to it. Document in the patient's chart, not on other family member records. Do not place calls to the patient's home to discuss abuse without permission from the patient. (Abusers often listen in, tape, or use Caller ID to monitor their victims.) When filing sensitive information, consider who may have access to files and computer records, particularly if a victim's family member or friend works in the medical setting. (ICSI, 1996)

Believe what the victim says. Too often, individuals discount victims' accounts or erroneously label patients, e.g., "He's just suffering from dementia" or "She's co-dependent."

Examples of Preface Questions

- "Because violence in our society is so common, I ask all my patients some private questions about their relationships...."
- "We know here at [NAME OF PROVIDER] that how a person is treated at home will affect his or her health. So I'm going to ask you a few questions about your relationship with your spouse/partner/adult child."

Examples of Indirect Questions

- "How are things going in your relationship with your spouse/partner/adult child at home?"
- "Tell me about what your spouse/partner/adult child does when angry."
- "You mentioned to me that your spouse/partner/adult child loses his or her temper. Can you tell me more about that?"
- "You seem to have some special concern about your husband/wife/partner/adult child. Can you tell me more? Does he or she ever act in a way that frightens you?"
- "If you or someone you knew was being hurt by a family member or caregiver, would you know what resources are available in our community?"

The husband of a woman in her 70's regularly beat and kicked her throughout their 30 year marriage. He wouldn't let her have a telephone or any friends. Her only refuge was her work, as a certified nurse assistant at a hospital. Despite years of bruises, many in-patient stays at the hospital and other co-morbidity factors, none of her health care co-workers or providers ever asked about the abuse.

Examples of Direct Questions

- "Are you [Have you ever been] afraid of your spouse/partner/adult child?"
- "Have you ever been punched, kicked, hit or hurt in any way by a member of your family? Were you ever threatened or forced to do things you did not want to do?"
- "Is anyone important to you yelling at you, threatening you or otherwise trying to control your life?"
- "Is anyone insisting you give them money or threatening you if you don't?"
- "Have you ever been forced to do sexual acts you did not wish to do? Is this going on now?"
- "Many patients come to me with injuries or symptoms like yours and tell me they have been hurt by a family member. Is this happening to you or has it in the past?"

If YES…first demonstrate that you listened and heard through statements such as:

- "I am very sorry to hear this."
- "No one deserves to be hurt or harmed."
- "It's not your fault. He has to take responsibility for his behavior."
- "This clinic/hospital cares about your health, so please know you can always talk to me about this."
- "Is this happening currently? Tell me more… How are you staying safe now?"
- "Unfortunately, these situations rarely stop on their own. In fact, usually they keep escalating, so let's talk about your safety."
- "There are many resources in the community that can help you and I want to talk to you about how to help you be safe."
- Do you feel safe now?"

"Why did I tell the doctor about my husband's abuse? Because he was the first person who ever asked me. I had made up my mind that if a doctor ever asked, I'd tell. The clinic then told me about the Older Women's Support Group in town. That changed my life."

-81 year-old survivor

If NO…

- "I'm glad to hear that. Unfortunately, that's just not the case for so many older people in our community. So if it ever does happen to you or someone you care about, we'd want to let you know about resources in the community that we can share with you."

It is equally important to keep in mind how *not* to screen for abuse:

- Avoid asking leading questions that convey judgment and do not invite disclosure (e.g., "You're not being abused, are you?")
- Be careful about ambiguous questions – e.g., "Are you safe?" (Elder patients will generally think of fall risks or safety from burglars or robberies.)
- Do not minimize or trivialize.
- Never laugh or joke.
- You do not need to apologize for asking (e.g., "I'm sure it doesn't apply to you, but they make me ask these questions ….")

If Family Abuse is Suspected, But Not Disclosed by the Patient

Following screening questions and the examination, you may suspect that the patient is being abused. If the victim does not disclose abuse to you, you have not wasted your efforts. Many victims believe they cannot escape the abuse and will be in greater danger if they tell anyone what is happening. For example, spouses may believe that their marriage vows compel them to preserve their marriage at all costs. Parents of abusive adult children may feel responsible for their children's actions or feel sorry for them. They may not want to "get them in trouble," think that the abusive adult child "just needs some help" or that it will soon stop. Language and cultural barriers may also prevent the patient from being able to confide in you and other health care professionals. Abusers may have so isolated victims and destroyed their self-esteem that the victims believe that the abuse is their own fault and that no one would ever help them. Immigrant women may fear deportation. Gay men and lesbians may fear repercussions from friends, family members or the community if they have not previously disclosed their relationship and the abuse. Former attempts at getting help may have been futile or escalated the violence.

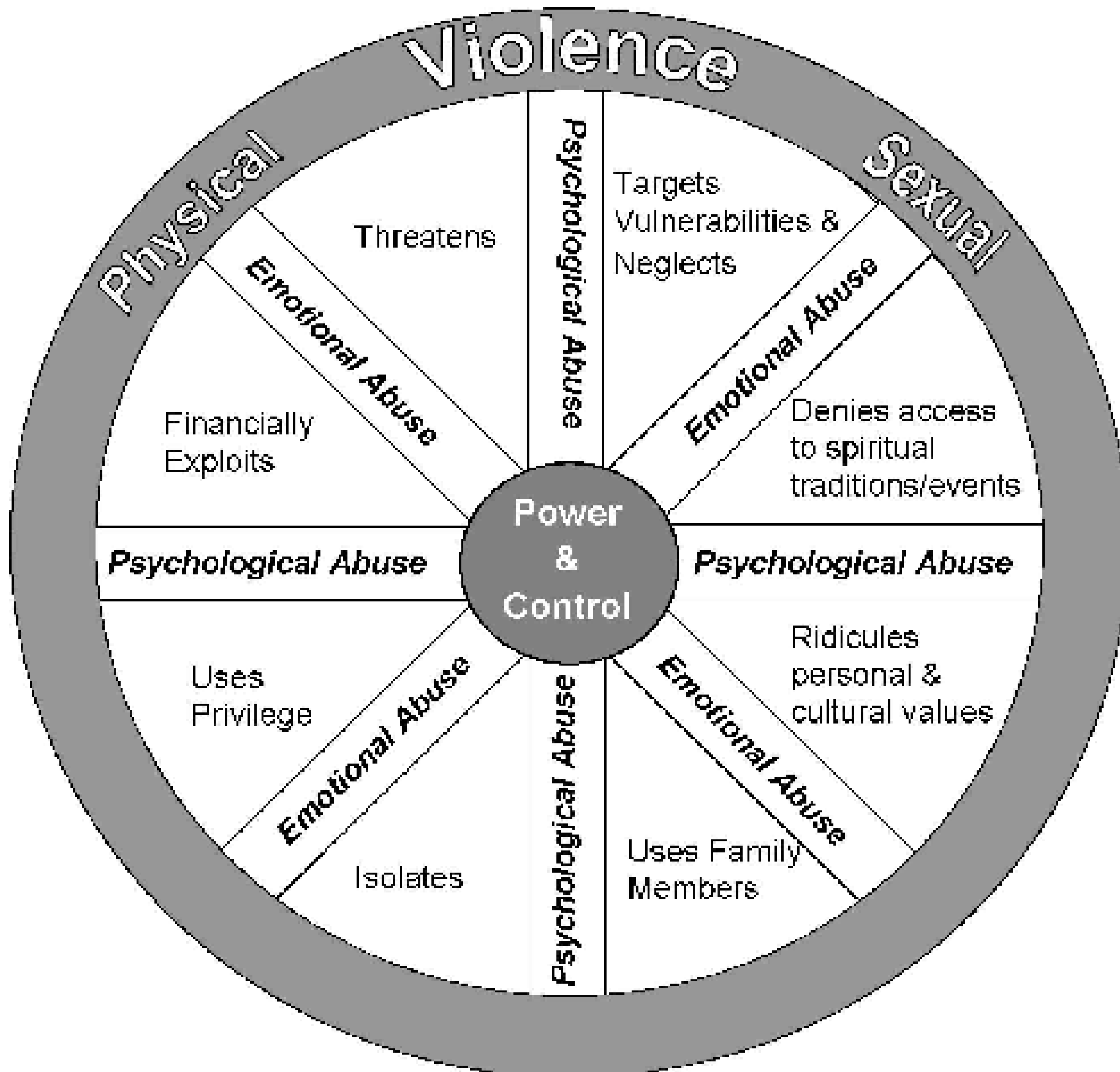
You may question the mental capacity of some patients during the initial interview. Mental capacity should be tested only if there is evidence that the person has cognitive limitations. If the victim's choices are causing you discomfort, take care not to allow this to influence your assessment. Professionals often question the mental capacity of older people who have symptoms such as passivity, withdrawal, lack of initiative, lack of reactivity, the inability to make use of new information, lack of drive, impairment of insight, impulsiveness and poor judgment. However these symptoms are also common reactions to victimization. Often, with food, rest, a review of medications, and an opportunity to talk about the abuse, many of these symptoms disappear in a few days. When working with patients with suspected cognitive impairments, it may be helpful to consult your local elder abuse or adult protective services agency.

If the patient confirms abuse is occurring, follow the steps on the flow chart. (See page 11.) Affirm that you heard her or him, provide support and affirmation, ask about how you could help right now, talk about safety at the clinic, at home and in other settings and address any clinical effects of the abuse. Then document your observations, provide additional information about local resources and provide options.

IDENTIFY AND ADDRESS INJURIES, HEALTH CONSEQUENCNES OF ABUSE, AND FEARS

During the examination and routine questioning, identify any injuries, symptoms or other clinical effects the patient may have as a result of the abuse. If the patient wants to talk about the abuse, be open and willing to listen. Emphasize that no one deserves to be hurt, physically or emotionally. Look beyond the physical signs of abuse and ask about emotional abuse, financial exploitation and isolation. One method for having this discussion is to use the "Family Violence in Later Life" power and control wheel: http://www.ncall.us/docs/Later_Life_PCWheel.pdf. (See page 17.)

Abuse in Later Life Wheel



Created by the National Clearinghouse on Abuse in Later Life (NCALL), a project of the Wisconsin Coalition Against Domestic Violence (WCADV)
307 S. Paterson St., Suite 1, Madison, WI 53703 608-255-0539
www.ncall.us/www.wcadv.org

This diagram adapted from the Power and Control/Equality wheels developed by the Domestic Abuse Intervention Project, Duluth, MN

Permission to Adapt 2006

ADDRESS SAFETY ISSUES

Ask the patient what he or she needs right now and about the patient's greatest concerns. Don't be surprised if the response is not a medical need. Ask if there are weapons in the home, which is a high predictor for danger. Ask about any pets, and what the pets need, as this is often an important consideration in making decisions about staying or leaving. Gathering information will lead to offering beneficial options and planning for the patient's safety. (Campbell, 2005)

DOCUMENT INJURIES

Domestic violence advocates, health care professionals, and criminal justice personnel agree that proper documentation of domestic abuse in medical records is essential for many reasons. These include: continuity of care; evidence in a future court proceeding; justification for funding and changes in public policies; reimbursement/coding; risk management for the provider or institution; and justification for services to insurance companies, Medicaid, HMOs and other data-driven systems. (Goldman, et al., 2000)

Document injuries by taking pictures or drawing on body maps. Since bruises change over time, photograph for a several-day period if possible. Ask the patient to sign a consent form to photograph injuries. In the written history, include information about who caused the injury, how the injury occurred, and if the injuries are consistent with the patient's explanation of the cause. Write complete notes about what was said, observed, and done. Include direct quotes of what the patient said happened and/or statements made by the suspected abuser. Avoid language such as "alleges," which suggests you do not believe the information given or that you are preparing the notes for court actions. Do not write judgment statements about the victim such as "she was hysterical and overreacting" or "he was evasive." This is an opinion; the reaction may have been perfectly appropriate given the circumstances. Finally, document what interventions were offered (e.g., police, social services, safety planning) and the outcomes (e.g., accepted brochures, consulted with a social worker). [Institute for Clinical Systems Integration, 1996]

Whether you have a paper or an electronic health care record system, there are many opportunities to discretely "flag the chart" for follow-up. In some cases a provider may want to simply note on the chart the possibility of a problem; in others, the provider is "requesting" that the health care entity's domestic violence professional speak to the patient. In the first case, the provider can apply an explicit diagnosis to the patient's chart that could be made to put the patient on a call list or other watch list, depending on the goal. The second case can be done as an electronic order, much like an order for an x-ray, but with different routing. If you have concerns about a hovering abuser or someone with access to the patient's file, you should set up synonyms or aliases orders that have no meaning to someone outside the system.

A note about HIPPA: Under the federal HIPPA Privacy Rule, covered entities may share information that is directly relevant to the involvement of a spouse, family members, friends or other persons involved in the patient's care, only if the patient agrees or if under the circumstances the health care professional can reasonably infer that the patient does not object. However, HIPAA permits health care providers to not disclose information, even to legally authorized representatives, if the health care provider suspects abuse, domestic violence or for any other reason the provider doesn't believe it would be in the patient's best interests.

DISCUSS OPTIONS AND PROVIDE REFERRALS

Health care professionals can offer basic information about the help that may be available from the medical, legal, social service, aging and domestic violence fields. Often, the first step is suggesting that the patient talk with an elder abuse specialist, health care social worker or health care or community program's domestic violence advocate.

Communicate Support and Belief. Batterers often use a variety of "crazy-making tactics" so that victims feel unsure of themselves. For example, batterers often hide things, lie, or provide medications inappropriately so that the elder will appear confused. Abusers tell their victims repeatedly that they are to blame for the abuse.

Health care professionals can provide support and assurance to victims by listening empathetically to their stories and making supportive statements such as: "You are not responsible for the violence and abuse." "The abuser's actions are wrong and not your fault." "I understand how hard this must be for you to talk about." "I believe you."

Educate on Elder Abuse and Domestic Violence

Many victims feel they are the only ones experiencing abuse. Education about the frequency of domestic violence and elder abuse may be especially helpful. Let patients know that abuse rarely ends on its own; it usually continues or escalates without some type of outside intervention. Assure patients that their reactions are common for victims of abuse and praise their personal courage and strength. Validate and support the choices the patients make to stay safe and alive.

Plan for Safety

People who live with domestic abuse often want the abuse to end and the relationship to continue. This is especially true in situations involving abusive adult children. Stating your concerns about their health and the extent of their injuries and/or emotional trauma may be helpful. Information from professionals that confirms patients' fears, reassures them that the abuse is not their fault, and reinforces that the abuse may escalate can help them more realistically explore their options.

Safety planning is an ongoing process. Ideally, the health care provider and victim discuss safety options for the victim's particular set of circumstances. Questions may include:

- What have you done to keep safe in the past?
- If the violence escalates, do you have a place to go?
- Can you call the police or a neighbor, someone in your family/one of your [other] children, etc.? If you leave, where can you go?
- What do you need to bring?
- If you decide to return, how can you plan for your safety and get support?
- Safety planning tools are available from the Wisconsin Coalition Against Domestic Violence (http://www.wcadv.org/?go=gethelp/plan) or your local domestic abuse program.

Sometimes safety planning requires creative thinking. One idea is to write the domestic violence or elder abuse crisis line number in code on medical papers (such as prescription pads) so that the victim will be able to keep the number handy without raising the abuser's suspicion. Another suggestion is to recommend a personal emergency response system (necklace or bracelet with a button to contact medical personnel in case of an emergency) for safety. In some communities, an elder can use a personal emergency response system for both medical emergencies and domestic abuse situations. The system staff will then call the elder when he or she presses the button. If the staff cannot talk directly with the elder, they will call the police to investigate.

Assist in Accessing Additional Services

The services you offer will depend on your patient's wishes and needs. Many victims of abuse benefit from free domestic abuse services including emergency shelter (if they choose to leave the abuser), support groups, peer counseling, and crisis lines. Some victims will want to use the legal system to have the abuser arrested, get a restraining order or divorce, or establish a durable power of attorney. Other victims may benefit from services from the aging network such as transportation, peer support, supportive home care, home-delivered meals, or financial or benefit counseling. The health care provider, hospital domestic abuse advocate, or social worker can work with the patient to access the services that best meet the patient's needs.

Offer Follow-up

Finally, offer to follow up whether or not the patient agrees to access resources and available services. The decision to end a relationship (with a new spouse/partner, a long-term spouse/partner, or an adult child or grandchild) can be agonizing and painful. Various components, including economic, emotional and spiritual factors, play a part in the victim's/patient's decisions. Few victims leave the abuser the first time they reach out for help. Many victims of abuse leave and return to their abusers an average of four to seven times. Keep in mind that victims and those they care about are most often in danger of being killed or seriously injured when they are ending a relationship. (Campbell, 1992)

Some victims will choose to continue the relationship with their abuser. **They want the relationship to continue but the violence to end.** In some cases, abuse may escalate rather than diminish unless the abuser is held accountable for his or her behavior. Often, victims who maintain relationships with abusive family members will need ongoing safety planning and support. A support group may be extremely helpful, especially a group with people who are close to the same age as the victim. Older abused women's support groups exist in many communities in Wisconsin.

Your communication of support for the patient and the patient's health, no matter what decision the patient makes, plays an important part in the victim finding strength to make difficult choices.

If the Patient Does Not Wish to Access Services and is Mentally Competent

The above steps provide effective interventions for victims who are ready to receive help. Some victims may not be ready to ask for assistance. They may recognize they are in greater danger if they get assistance or may have had bad experiences working with professionals in the past. Interventions for these patients are described below.

Respect the Patient's Wishes

Often the abusers take power and control away from victims by isolating them from the people and information that can help them make thoughtful choices. Sometimes service providers unintentionally control access to information and develop goals and expectations for patients. Helpers may unwittingly become like the batterer as they attempt to manage the victim's life using their professional influence and power. Professionals must not judge their patient's choices or use tactics to have the patient cooperate with the professional's agenda.

After acknowledging respect for the patient's decision to not accept services at this time, the steps are the same as for a patient who has accepted services: communicate support and belief, educate on elder abuse and domestic violence, and plan for safety. If it is safe, give the patient information and referral phone numbers to allow him or her to access these services in the future. Finally, offer follow-up. Document disclosures and interventions carefully.

If the Patient Is Not Competent or You Question the Patient's Competence

If you are concerned that you are working with a patient who is not competent to make decisions about safety, follow the medical protocol at your facility to determine competency. Keep in mind that many of the symptoms of dementia, depression, and delirium (for example, poor judgment, confusion, lethargy, inability to communicate clearly) are also common and normal responses to victimization. Also, many dementias are totally reversible because they are actually the result of improper nutrition or hydration, an untreated infection, anxiety, depression, a recent fall, or improper medication management. The mental condition of many patients improves significantly within a few days when they feel safe and have had food, hydration, proper doses of medication, and sleep.

If you assess a patient and determine him to her to be incompetent, contact the county lead elder abuse agency in your county for consultation on the remedies (including legal options) and services available.

COMMONLY ASKED QUESTIONS

When should I report abuse?

Many patients do not want you to report their situation of abuse to either law enforcement or the county lead elder abuse agency. In Wisconsin, competent patients have the right to self-determination and to choose or refuse additional assistance. When the abuse is by a family member, elder victims often feel great shame and embarrassment. Some may not identify the behavior as abusive. Others may recognize it as abuse but may minimize its importance because of "not wanting to get the abuser in trouble." And for still others, if the abuser is providing some care, the victim may fear that if someone makes a report and authorities remove the abuser from the home, the victim may end up without some needed care, or even worse, be placed in an institution.

Some patients feel their safety will be jeopardized if someone makes a report to outside officials. Many abusers are most dangerous when they fear the relationship may be ending or professionals may be trying to "take away their control." A patient who does not consent to reporting to social services or law enforcement may have had poor past experiences and fear future reprisals. **Whenever possible, respect the patient's wishes.**

However, there are specific limited circumstances in which health care professionals must report situations of elder abuse either to law enforcement or to the county lead elder abuse agency. Wisconsin has no general mandatory reporting law for domestic violence. Rather, a Wisconsin law relating to confidentiality of health care records requires health care providers to report to law enforcement only when there are gunshot wounds, wounds resulting from suspected crimes, or 2nd or 3rd degree burns on at least 5% of the body.

Given the importance of respecting patients' rights, the potential danger to a victim if the report is made, and the intent of the statute, the Wisconsin Medical Society's House of Delegates developed a policy on domestic violence of adults, keeping patient autonomy and safety as paramount goals. The policy, in place since 1994 and revised and affirmed in 2008, states in part:

> ***Domestic Violence in Adults:*** *Wisconsin physicians recognize the prevalence of domestic violence and acknowledge that it is a significant cause of death and injuries that has long term health consequences for their patients. It is therefore of the utmost importance for Wisconsin physicians to assess patients for this abuse. In treating adult patients who are possible victims of domestic violence, the goal of intervention must be to help victims regain control of their lives. Because research confirms that reporting to law enforcement without the victim's consent can further endanger victims, it is vital that physicians pay great respect to a patient's right not to disclose domestic abuse or to refuse intervention when the patient believes such action is not in his or her best interest. The role of the physician in this process is to offer patients options and allow them to make the decisions in their lives. The patient's decision should be documented in the medical record.*
>
> . . .

It is therefore the obligation of physicians or their teams to: (1) privately identify and screen for abuse; (2) respond appropriately to abuse disclosures; (3) assess safety issues; (4) address clinical effects of abuse; (5) refer patients to appropriate community and health care provider services; and (6) carefully and discretely document disclosures in the medical record. (WMS Policy Compendium:VIO-008)

In addition, as of December 1, 2006, Wisconsin health care providers must report situations of abuse and neglect of "elder adults at risk" (see definition, page 4), even without the patient's consent, if they suspect or observe abuse, neglect, self-neglect or financial exploitation of an elder adult at risk whom they have seen in the course of their professional duties only in either of these very limited situations:

(1) the health care provider reasonably believes the elder adult at risk is at imminent risk of serious bodily harm, death, sexual assault or significant property loss and is unable to make an informed judgment about whether to report the risk; or

(2) other adults at risk are at risk of serious bodily harm, death, sexual assault or significant property loss by the suspected perpetrator.

Even in these two circumstances, no reporting is required if the health care provider determines it is not in the best interest of the patient to report and so documents in the patient's file.

In addition, Wisconsin Administrative Code HFS 13 requires certain entities and health care providers to report suspected abuse that occurs in their facilities or health care programs. (For more detailed information about these provisions, see: http://dhs.wisconsin.gov/rl_DSL/publications/06-028.htm.)

How do I make an elder abuse report?

Each county has established a county lead elder abuse agency. In addition to the very limited required reporting listed above, anyone who suspects elder abuse may call the local agency and make a report. If possible, callers should be prepared to report what happened, when, where it happened, and who the suspected abuser might be. The law requires counties to initiate their response within 24 hours, excluding weekends and holidays. Contact the county lead elder abuse agency for an investigation and offer of services (http://dhs.wisconsin.gov/aps/contacts/eaaragencies.htm). Even if you are unsure whether a situation warrants an investigation, contact your county lead elder abuse agency for consultation. Case consultations can occur without revealing any patient-identifying information (e.g., name, address, etc.).

A health care provider may release health care records to an agency investigating elder abuse without receiving a request for information. The law protects the caller's identity and all reports are confidential. The law similarly provides civil and criminal immunity and protection against charges of unprofessional conduct for all reports made in good faith.

Note: If a county lead elder abuse agency requests a patient's health care records for an investigation, Wisconsin law requires you to release the information.

What do I say to the patient if I must file a report?

Inform the patient respectfully. Discuss with the patient what you must report and why. For example, "I've heard your concerns about contacting law enforcement/the county lead elder abuse agency. However, I'm compelled under state statutes to report cases such as yours to them. I am very concerned about your health and your safety. I would like to take the time now to talk with you about safety planning and follow-up medical appointments."

What other services may be available to victims of family abuse?

Domestic abuse programs. Domestic violence advocates can help domestic violence victims of all ages with planning for safety, obtaining emergency housing, food, and clothing, and accessing counseling and support groups. Most domestic abuse programs have legal advocacy components that can help with protection orders.

http://www.wcadv.org/?go=gethelp – for Wisconsin

The national domestic abuse crisis hotline number is **1-800-799-SAFE (1-800-787-3224 TDD) .**

Aging network services. Wisconsin's aging network can offer services such as benefits counseling, transportation, home health care, home delivered meals, assistance with home maintenance, and recreational activities. To find out about services in your area, call your county aging unit (http://dhs.wisconsin.gov/aging/contacts/COAGOF.HTM). Other statewide agencies and numbers are listed, starting on page 32.

Can I use Medicare to assist victims of family violence?

Yes, Adult Maltreatment Syndrome is assigned code #995.81 in the International Classifications of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). A case could fall into either DRG #454 - other injury, poisoning and toxic effect diagnosis with complication or co-morbidity, or DRG #455 - other injury, poisoning and toxic effect diagnosis without complications or co-morbidity.

While unconscious after heart surgery, an 82 year-old woman's long-time abusive husband manipulated the hospital staff into not disclosing her status to her children. Later, despite a restraining order in place, he tricked the hospital into telling him the name of the rehab facility to which she was transferred. Once the restraining order was enforced and he was prohibited from access to her, he committed suicide. "I can't believe I'm finally free," she says.

What interventions might be dangerous to older victims of family violence?

Prescribing antidepressants or sedatives without a thorough assessment

Physicians often offer medications to older people and victims of family violence rather than support and assistance to live free from violence. Prescribed medications may lessen a person's ability to respond effectively in a crisis. Medications can also send a message to the patient that "you are the problem" or mimic messages from the batterer that "you are crazy."

Recommending couples or family counseling without treatment for the batterer

Couples counseling has been found to be dangerous to victims of abuse if used before the batterer has accepted full responsibility for the abusive behavior and stopped the violence. Victims have been injured following couples counseling sessions. Another danger is that some counselors will focus on the interaction of the couple without recognizing the danger to the victim. Couples and family counseling is contraindicated unless the abuser has successfully completed a batterers treatment program. (Brandl and Horan, 2002; Golden and Frank, 1988; Schechter, 1987)

Blaming the victim

Often, professionals wonder why victims stay or offer remedies that suggest that if the patient would try a little harder, the abuse would not occur. Without an understanding of the dynamics of family abuse, health care providers may be frustrated by patients who use the health care system regularly without leaving the abusive relationship. (Zink et al., 2004; Brandl and Horan, 2002; Worcester, 1992) However, rather than focus on the patient's choices, it is important to remember that abusers are solely responsible for their behavior and must be held accountable for their actions. When we blame victims, we let the abusers off the hook. (Schechter, 1987) We also place the victim in greater danger by labeling the victim, not the abuser, as the problem.

Colluding with the batterer

Supporting abusers by conveying that you "understand how difficult their lives are," agreeing that "sometimes these things happen" or that "on occasion violence against a spouse/partner or relative is justified," reinforces abusers' beliefs that they are entitled to use whatever means necessary to get their way.

Escalating her danger or further keeping her feeling trapped

When professionals normalize the victimization or trivialize or minimize the abuse, they increase a victim's feeling of being trapped. Further, they increase her danger when they disrespect her autonomy, ignore her need for safety, or violate her confidentiality.

What else can I do to help older victims of family violence?

- **Work with your community's domestic violence program or other domestic violence specialists to establish an older women's support group at your hospital or clinic.**

  Many battered women find support groups helpful in breaking their isolation and reassuring them that they are not alone. Support groups designed specifically for older women have been very successful interventions in Wisconsin. For more information on how to start services for older abused women, contact the Wisconsin Coalition Against Domestic Violence (www.wcadv.org).

- **Learn about and educate other health care professionals on elder abuse and domestic violence.**

  The Wisconsin Coalition Against Domestic Violence and the Wisconsin Bureau of Aging and Disability Resources all have information about elder abuse, domestic violence, and how to train health care workers. See **Wisconsin Resources**, starting on page 32.

- **Participate in local or statewide efforts to improve options for battered women and elder abuse victims.**

  You can work with your local program by volunteering or assisting with fundraising. Local Coordinated Community Response teams (CCRs) or Elder Abuse Interdisciplinary Teams (I-Teams) can greatly profit from having a health care provider's input. To have a statewide impact, you can join or financially support the WCADV.

- **Join health care organizations working to eliminate family violence such as Physicians for Social Responsibility, Physicians for a Violence-Free Society, or Nursing Network on Violence Against Women International.**

CONCLUSION

Health care providers are in a key position to assist older victims of abuse. Given the large numbers and high frequency with which older persons access medical services, health care providers are on the "front line" for detecting and appropriately responding to abuse. You have an opportunity to identify abusive behavior and offer help to your patients. Given the number of elders currently being abused and the rapidly increasing numbers of older people, now is the time for you to make a difference in the lives of your patients who are abused.

Medical Power & Control Wheel

ESCALATING DANGER

VIOLATING CONFIDENTIALITY: Interviewing her in front of family members. Telling colleagues issues discussed in confidence without her consent. Calling the police without her consent.

TRIVIALIZING AND MINIMIZING THE ABUSE: Not taking the danger she feels seriously. Expecting tolerance because of the number of years in the relationship.

BLAMING THE VICTIM: Asking what she did to provoke the abuse. Focusing on her as the problem and asking, "Why don't you just leave?," "Why do you put up with it?," or "Why do you let him do that to you?"

NOT RESPECTING HER AUTONOMY: "Prescribing" divorce, sedative medications, going to a shelter, couples counseling, or the involvement of law enforcement. Punishing her for not taking your advice.

IGNORING THE NEED FOR SAFETY: Failing to recognize her sense of danger. Being unwilling to ask, "Is it safe to go home?" or "Do you have a place to go if the abuse escalates?"

NORMALIZING VICTIMIZATION: Failing to respond to her disclosure of abuse. Acceptance of intimidation as normal in relationships. Belief that abuse is the outcome of non-compliance with patriarchy.

Medical Power & Control

INCREASED ENTRAPMENT

Produced and distributed by:

Developed by: The Domestic Violence Project, Kenosha, WI, adapted from the original wheel by the Domestic Abuse Intervention Project
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512.407.9020 (phone and fax) • www.ncdsv.org

ADVOCACY EMPOWERMENT WHEEL

Empowerment Through Advocacy

RESPECT CONFIDENTIALITY:
All discussions must occur in private, without other family members present. This is essential in building trust and ensuring her safety.

BELIEVE HER AND VALIDATE HER EXPERIENCES:
Listen to her and believe her. Acknowledge her feelings and let her know she is not alone; many women have similar experiences.

ACKNOWLEDGE THE INJUSTICE:
The violence perpetrated against her is not her fault. No one deserves to be abused.

RESPECT HER AUTONOMY:
Respect her right to make decisions in her own life, when she is ready. She is the expert in her life.

HELP HER PLAN FOR FUTURE SAFETY:
What has she tried in the past to keep herself safe? Is it working? Does she have a place to go if she needs to escape?

PROMOTE ACCESS TO COMMUNITY SERVICES:
Know the resources in your community. Is there a hotline and shelter for battered women?

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National Resources

National Clearinghouse on Abuse in Later Life
A project of the Wisconsin Coalition Against Domestic Violence
307 S. Paterson St., Suite 1
Madison, WI 53703
608-255-0539
608-255-3560 – FAX
www.ncall.us

Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
415-252-8900
415-252-8991 – FAX
www.endabuse.org/programs/healthcare
The Fund has a resource manual titled "Improving the Health Care Response to Domestic Violence," information packets, practitioner reference cards and safety information cards.

National Center on Elder Abuse
1225 "I" St., N.W., Suite 725
Washington, D.C. 20005
202-898-2586
202-898-2583 – FAX
www.elderabusecenter.org

National Domestic Violence Hotline Number
800-799-SAFE (7233)
800-787-3224 (TDD)
http://www.ndvh.org

National Resource Center on Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112
800-537-2238
717-545-9456 – FAX
www.nrcdv.org

National Sexual Violence Resource Center
123 North Enola Drive
Enola, PA 17025
717-909-0710
717-909-0714 FAX
717-909-0715 TTY
877-739-3895 Toll Free
www.nsvrc.org

For model **Screening and Intervention Protocols for Health Care**, see:
www.endabuse.org/programs/healthcare/ - Family Violence Prevention Fund, San Francisco

www.brighamandwomens.org/communityprograms/PassagewayScreening.pdf - Brigham and Women's Hospital, Boston

Wisconsin Resources

The **Wisconsin Coalition Against Domestic Violence** is a statewide membership organization of domestic abuse programs, formerly battered women, and other individuals who have joined together to speak with one voice against domestic abuse. As a statewide resource center on domestic violence, WCADV offers:

- training and technical assistance to domestic abuse programs;
- a quarterly newsletter;
- forums for the involvement of battered women;
- networking and support for programs for battered women and for professionals in related fields;
- training for professionals in legal, medical, social service, child welfare, housing, education and mental health fields and for employers throughout Wisconsin;
- technical legal assistance for attorneys, legal advocates, prosecutors and public defenders and limited funds for victims to acquire direct legal assistance.

WCADV has safety plans, power and control wheels, public awareness and other materials on domestic abuse in later life available for purchase. You may contact WCADV at 307 S. Paterson St., Suite 1, Madison, WI 53703; phone 608-255-0539, FAX 608-255-3560. www.wcadv.org. Click on "What We Do" and then on "Health Care Project."

The Wisconsin Department of Health Services' Bureau of Aging and Disability Resources

The Bureau of Aging and Disability Resources (BADR) has responsibility for analyzing public policy options and for planning and managing the delivery of services for persons who are elderly, persons with physical disabilities, persons in need of elder abuse and/or adult protective services and persons who need or receive community-based long term support. The Bureau carries out its responsibilities in a way that actively promotes individual choice, dignity, reputation, relationships, overall health, community participation, and self-sufficiency.

For more information on the Bureau telephone 608-266-2536 or write: Bureau of Aging and Disability Resources, One West Wilson St., P.O. Box 7851, Madison, WI 53707-7851. http://dhs.wisconsin.gov/aging/#tomaincontent

Advocacy and Protection Systems for Wisconsin Elderly

ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

Bureau of Prevention, Treatment and Recovery, 608-266-2717

The Bureau functions as a statewide administrator of publicly funded substance abuse services and can provide statewide information on publicly funded AODA services (e.g., outpatient, residential, crisis intervention and community support). For information on programs within a local area, referrals are made to county human services departments or departments of community programs.

http://dhs.wisconsin.gov/substabuse/

DOMESTIC VIOLENCE

Wisconsin Coalition Against Domestic Violence, 608-255-0539

WCADV is a statewide membership organization of battered women, formerly battered women, domestic abuse programs, and all committed to ending domestic violence. Through partnerships and strategic collaborations and education, advocacy and social action, WCADV works to prevent and eliminate domestic violence. WCADV has specialized staff on Aging and Disabilities issues and Health Care.
www.wcadv.org

ELDER ABUSE AND NEGLECT

Wisconsin Bureau of Aging and Disability Resources, 608-266-2536
Can provide case consultation and a list of elder abuse agencies throughout the state.
http://dhs.wisconsin.gov/aging/elderabuse/

LEGAL ADVICE FOR THE ELDERLY

Coalition of Wisconsin Aging Groups, 608-224-0660
Provides legal assistance to and advocacy on behalf of the elderly (those 60 years and older), develops and publishes materials on topics of elder law and insurance.
www.cwag.org

Elderly Benefit Specialist Program
Operated by county aging units. Offers assistance to older persons (60+) with their private and government benefits, such as private insurance or Medicare, and with the extensive and complicated paperwork that is often required in benefit programs. http://dhs.wisconsin.gov/aging/genage/BENSPECS.HTM

MENTAL HEALTH

Bureau of Prevention, Treatment and Recovery, 608-266-2717
Provides information on publicly-funded local mental health services (e.g., outpatient treatment, crisis intervention, community support). http://dhs.wisconsin.gov/MH_BCMH/index.htm

NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES

Long Term Care Ombudsman Program, 800-815-0015
Operated by the Board on Aging and Long Term Care, is a state agency that responds to complaints in nursing homes and other long-term care residential facilities and advocates on behalf of residents. Refers licensing violations to state agencies charged with enforcement actions. http://longtermcare.state.wi.us/home/ombudsman.htm

OLDER BATTERED WOMEN

Wisconsin Coalition Against Domestic Violence, 608-255-0539
Statewide organization that provides training and technical assistance about domestic violence, including domestic violence in later life and referrals for direct services. www.wcadv.org

RAPE AND SEXUAL ASSAULT

Wisconsin Coalition Against Sexual Assault, 608-257-1516
Statewide organization that provides assistance, including referrals to local programs, to victims of sexual abuse and assault. www.wcasa.org