National Institutes of Health

NIH Workshop: Multiple Approaches to Understanding and Preventing Elder Abuse and Mistreatment

Summary—October 30, 2015

Location: Claude D. Pepper Building (#31), C Wing, 6th Floor, Room 6, National Institutes of Health, Bethesda, Maryland

Executive Summary

Workshop Purpose

The purpose of this one-day workshop was to convene researchers working in fields related to elder abuse, and to identify research gaps and opportunities that could benefit from cross-disciplinary insights. Panelists included experts on elder abuse, intimate partner violence (IPV), child abuse, emergency medicine, and neuroscience. A videocast of the meeting is available.

Major Themes

Several major themes emerged through the presentations and discussions.

1. Need for basic research
    a. Basic research needs include improved screening and decision aids, including biomarkers and screening tools. Additional research on the complexity of cognitive impairment, including research on diverse cognitive skills and social capacity, is also needed.
2. Need for specific prevalence studies
    a. A number of large-scale prevalence studies have already been done, though prevalence studies for specific populations, such as people with cognitive impairment, may still be needed.
3. Need for intervention studies
    a. There is a very limited evidence base for intervention approaches. Studies need to consider cognitive impairment, caregiver burdens and skills, cultural contexts, hard to reach populations, strategies for ongoing engagement, and various settings where abuse may occur or be detected. More research is needed on integrated, multi-faceted intervention approaches. There have been significant advances in intervention studies for child abuse and intimate partner violence.
4. Need to reconsider successful outcomes
    a. The goal of extricating victims from their households is often not what is best or most desirable by the victim. Preventing re-victimization and reducing risk may be more desirable outcomes for the potential victims, rather than removing them from abusive contexts.
5. Need to understand the interplay of multiple forms of abuse
    a. Research advances from other fields hold significant promise for applications in elder abuse, including increased attention to the burden on individuals suffering from multiple forms of abuse (polyvictimization) and longitudinal abuse or adversity across

the lifespan. Different types of abuse can be masked when definitions of elder abuse are too limited and fail to take into account longitudinal and cross-sectional contexts of abuse.

6. Need for improved research infrastructure
    a. Elder abuse research faces several research infrastructure challenges, in part because of the small size of the research community. Institutional review board (IRB) members and study section members often are unfamiliar with elder abuse research, which can impede funding and protocol approval; templates and other tools could facilitate IRB review for addressing ethical considerations. Additional mentoring and training for early career scientists is essential. Cross-disciplinary teams, centers and consortia have great potential to facilitate research advances, and could enable long-term multi-site intervention studies that have standardized measures data collection.

Welcome and Introductory Remarks

Kate Saylor, M.S. *(NIH Office of the Director)*
Nora Super, M.P.A. *(White House Conference on Aging)*
Marie Bernard, M.D. *(Deputy Director, National Institute on Aging)*
Janine Clayton, M.D. *(Director, NIH Office of Research on Women's Health)*

Ms. Saylor welcomed attendees, noting that this workshop was the result of a trans-National Institutes of Health (NIH) effort to explore avenues of identifying and addressing elder abuse (EA), prompted in part by priorities set at the recent White House Conference on Aging. The planning committee for this workshop included six Institutes and five offices across NIH that set key areas for discussion, which include:

- Scientific and structural barriers to building an evidence base
- Key findings in related fields that can inform EA research
- Research opportunities for EA in the next five to 10 years

Ms. Super described the federal government's efforts to increase visibility of and reduce elder abuse. The Elder Justice Act (passed as part of the Affordable Care Act in 2010) and the 2014 Elder Justice Roadmap Report have focused national efforts. Elder justice was one of four priority areas at the 6th decadal White House Conference on Aging (WHCOA) held in July 2015. Building a more robust evidence base for EA detection, prevention, and intervention was one of major needs the WHCOA promoted. WHCOA asked NIH to support this workshop on EA research, and Ms. Super commended the efforts of the NIH and the workshop participants.

Dr. Bernard highlighted relevant research funded by the National Institute on Aging (NIA) and the role of strategic planning and consensus reports in shaping research agendas. Although NIA has issued specific requests for applications on EA, the majority of NIA-funded awards focused on EA have been investigator-initiated. Dr. Bernard stressed the importance of leveraging current knowledge to expand our understanding of EA and of exploring synergies and collaborative opportunities across disciplines.

Dr. Clayton noted that although the burden of EA is difficult to measure, the Justice Department estimated that more than 5 million Americans are affected, costing billions of dollars annually. Although abuse is more frequent in women, EA is known to affect both men and women. Risk factors for EA abusers include mental illness, aggressive behavior, alcohol abuse, exposure to abuse as a child, and

poor preparation for caregiving. Members of the lesbian-gay-bisexual-transgender community and people with dementia are also at higher risk of being abused. NIH has an important role in developing and testing evidence-based solutions.

Overview of Relevant Reports and Previously Identified Research Priorities

Mark Lachs, M.D., M.P.H. *(Director of Geriatrics, New York Presbyterian Health System; Co-Chief, Division of Geriatrics and Palliative Medicine, Weill Cornell Medical College)*

Dr. Lachs provided an overview of major workshops, consensus reports and systematic reviews on elder abuse research from the past two decades and discussed progress and current barriers to EA research. Dr. Lachs reviewed the major evidence gaps (and some structural reasons for these gaps) identified in the 2003 Institute of Medicine (IOM) consensus report, "Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America." Deficiencies in the EA scientific literature noted in the 2003 IOM report included the lack of clear and consistent definitions, adequate measures, population-based data, prospective data, control groups, and systematic evaluation studies. Dr. Lachs noted that while several scientific, structural, and practical barriers to advancing elder abuse science remain, great progress has been made in EA research since the publication of the 2003 report. Advancements include the development of new population-based prevalence studies and longitudinal studies, the expansion of multidisciplinary research in EA, and the addition of junior researchers to the field.

Remaining barriers to the field include:

- Scientific barriers: Lack of fundamental basic science knowledge of EA, limited utility of familiar research designs (such as randomized controlled trials), lack of specific EA prospective data collection, and comorbidities and heterogeneity of abuse cases.
- Structural barriers: Regulatory reporting requirements, underreporting/undersampling of individuals at highest risk, hard to reach populations, and ongoing participant engagement and retention.
- Practical barriers: Inadequate understanding of EA research among peer reviewers and IRB members and lack of funding for junior researchers in EA.

Finally, Dr. Lachs proposed establishing interdisciplinary EA centers or networks to promote EA intervention through clinical care, scientific activity, and infrastructure and mentoring for researchers.

Panel 1: Identifying Abuse—Screening, Standards, and Detection Challenges

Moderator: Scott Beach, Ph.D. *(Associate Director, University Center for Social and Urban Research, University of Pittsburgh)*
Panelists: Tony Rosen, M.D., M.P.H.; Christopher Carpenter, M.D.; Phyllis Sharps, Ph.D., RN; Richard Gelles, Ph.D.

Dr. Beach introduced the panel themes, including: current screening and detection strategies used in community and institutional settings, unique challenges for screening older adults, promising screening tools and technology, and lessons learned from research findings on IPV and child abuse.

Panelists provided brief presentations related to their fields of expertise. Dr. Rosen discussed efforts to improve identification of and intervention for EA in health care settings, particularly in emergency departments. Dr. Carpenter spoke about risk stratification for older adults for short-term adverse outcomes, dementia, delirium, and falls. Dr. Sharps spoke about screening and intervening issues related to IPV among the elderly. Lastly, Dr. Gelles spoke about how strategies and procedures for screening and detection of child abuse may be applicable to EA.

Lessons Learned Related to Screening and Detection of EA

Methodology

- Evaluation by health care providers provides an important opportunity for identification of EA, however, there are methodological challenges to screening in health care settings, particularly in the emergency room (Dr. Rosen). Defining hallmarks of EA requires identification of injury patterns of confirmed cases of EA. To improve identification of physical abuse in elders, Dr. Rosen's group has been conducting a case-control study comparing injury patterns, physical findings, forensic biomarkers, and photographic evidence from physical elder abuse victims from legally adjudicated cases with those of control subjects who suffered accidental falls.
- Dr. Rosen's group has been developing and evaluating standardized protocols for photographing injuries in the acute care setting and a classification system to describe injuries in the elderly to derive a clinical decision instrument. A systematic review of clinical decision instruments in the emergency department and return visits, functional decline, and death indicates that these instruments have predictive value about geriatric injury.
- Although technology may enhance some aspects of screening and detection, a workshop attendee noted that "low-tech, high-touch" compassionate approaches can affect screening.
- Implementation of any potential screening and detection methods must always be considered (Dr. Carpenter).
- Mandatory reporting for child abuse has been successfully implemented, but only 15% of cases receive actual services. Methods for screening and detection of domestic violence through police reporting are also in place, but after offenders are arrested, there is not a standard toolbox of services to provide them. There is a danger of pushing victims and offenders into a vacuum (Dr. Gelles).

Intimate Partners

- EA between intimate partners falls into two distinct patterns: abuse that has occurred throughout the long-term relationship and has extended into old age, and late-onset abuse that may be related to retirement, disability (including cognitive impairment), new relationship roles, or changes in sexual activity (Dr. Sharps).
- According to the National Crime Victimization Survey, the lowest reported rate of domestic violence is in people 50 or older and has remained unchanged, suggesting that this is a distinct population of abusers who never aged out of their prior abusive behavior (Dr. Gelles).

Perpetrators

- The panelists noted that little research has focused on perpetrator detection. They acknowledged that many perpetrators may experience perceived burden, stress, anxiety, social isolation, or depression, which may be correlates or risk factors for EA. Perpetrators may also be elderly adults who require services and support.

Challenges Related to Screening and Detection of EA

Identification

- There are many methodological gaps hindering the identification of EA. Major challenges include difficulties in identifying an appropriate study population and distinguishing physical abuse from accidental trauma or illness (Dr. Rosen, others).
- Appropriate screening tools for EA are currently lacking, and this has implications for future research (Dr. Carpenter). Patient self-reports may not always be accurate. Outcome measures may be too broad to allow reliable detection and there may be unmeasured predictor variables.
- The U.S. Preventive Services Task Force cited a lack of sufficient evidence of the benefits and potential harms of screening to warrant universal screening of all elderly adults for EA. Recommendation was made to target older patients with risk factors for possible abuse, neglect, or financial exploitation (Dr. Sharps).
- A system of support for the victims and family members should be in place for effective intervention once EA has been identified (Dr. Gelles).
- Detecting changes in behavior or psychological symptoms that occur with EA requires the establishment of baseline measures for comparison (Dr. Carpenter). This presents a particular challenge for EA screening in the emergency room setting.
- Although prosecuted cases may help researchers understand EA, they may not adequately represent the entire population of EA cases, which include those that go undetected or unreported.

Setting

- The design of potential recommendations or guidelines must take into account setting-appropriate conditions (e.g., rural versus urban environments; Dr. Carpenter).

Implementation

- Challenges with implementation of guidelines and recommendations include awareness, acceptance, application, ability, action, agreement, and adherence (Dr. Carpenter).
- Practitioners already have numerous guidelines to follow; screening and detection methods should be straightforward and simple to implement, without added burden (Dr. Gelles).

Intimate Partners

- Panelists were undecided about whether abuse between intimate partners in EA should be considered separately from other forms of EA (Dr. Sharps).
- Support systems are necessary to establish and have in place for victims of late-onset EA.
- More research is needed to determine whether current screening questionnaires are appropriate for elderly women, particularly in the context of cognitive impairment (Dr. Sharps).
- EA is likely not late-onset abuse, which creates a challenge for modeling interventions (Dr. Gelles). There is likely no “one size fits all” approach to addressing EA.

Social Factors

- In older women, screening is affected by cultural attitudes (Dr. Sharps). Sexuality assessment and screening tools are currently lacking. Developmental differences (e.g., cognitive impairment, frailty, vulnerability) also affect screening. Some of these factors may vary by age, and factors affecting women in their 50s and 60s are likely to be different from those affecting women in their 80s and 90s.
- People who seek care in the emergency room are more likely to be flagged for potential maltreatment than those who go to private providers (Dr. Gelles). The setting where people seek care tends to be income driven.

Cognitive Impairment

- All panelists agreed that cognitive impairment in elderly patients presents a particular challenge in the identification of EA. More information is needed on whether current questionnaires are effective for screening the cognitively impaired (Dr. Sharps).

Research and Reporting

- Panelists and attendees also discussed existing challenges related to working with IRBs. IRBs commonly raise ethical questions concerning the limits and obligations of mandatory reporting requirements and the procedures for obtaining informed consent from people with cognitive impairment/screening for dementia. Studies of IPV also have consent issues. The panel agreed that this research can be conducted ethically and that key stakeholders should be informed about safeguards needed to protect human subjects.
- Legal issues related to reporting of abuse was also a concern. Panelists noted that some people may avoid seeking care for fear of being accused of EA.
- Enrollment into studies of EA (e.g., in emergency departments) can be challenging. In-home participation is even lower.
- Panel members discussed the importance and complexity of EA research in the context of scientific review of applications for research grants. All panelists agreed that more funding support is needed.

Opportunities in Screening and Detection of EA

Methodology

- One can use legal filings to locate confirmed cases of EA (Dr. Rosen). These cases allow access to information including injury patterns, physical findings, forensic biomarkers, and photographic evidence. This avenue of research could provide information to derive a clinical decision rule for health care providers to identify EA.
- The role of providers who screen for EA should be expanded to include health care professionals like radiologists, technicians, and emergency care providers (Dr. Rosen). National databases could be a source for information about the identification of EA. Medical students and volunteers might assist in the screening process (Dr. Carpenter). Nurses could be involved in cognitive ability assessment.
- Use of technology may permit enhanced screening methods for identification of EA (Dr. Sharps). Tablet computers can allow for privacy during screening and provide assistance for low-literacy patients or changes in font size for the visually impaired. The location of screening, including specific areas of the emergency room, should also be considered.
- Apply big data approaches to identify risks and markers for detection (Dr. Gelles).
- Create centers for EA study wherein the review boards and other groups understand the complexities and challenges of the research (panelist).

Implementation

- Education of all relevant providers is critical to the successful implementation of screening and detection methods (Dr. Carpenter).
- Use of a common framework enhances the value of research for dissemination and implementation.
- There are new reporting guidelines for abuse that all groups should follow. Harmonization could allow for comparative analysis across disciplines (Dr. Carpenter).

Intimate Partners

- Research on whether EA in clinical populations is distinct from other cases of EA is warranted (Dr. Sharps). It is questionable whether substance use or abuse or depression should trigger screening for IPV. Specific resources and support for elderly victims and the perpetrators was recommended.

Recommendations/Needs in Screening and Detection in EA

Methodology

- Establish clinical trials with prospective subject enrollment to allow complete evaluation of victims of EA. These trials would improve our understanding of characteristics of EA and help identify differences from non-abuse injuries that can occur in an elderly population (Dr. Rosen). Focus on interventions and outcomes.
- Create a blueprint for what works for whom. Recommended expanding the experts who would contribute to research and policy related to EA (Dr. Gelles). Evaluate current and future interventions to understand their efficacy.
- Standardization in outcome measures and definitions is needed. Unmeasured confounders include health literacy, social factors, cognitive impairment, and frailty.

Evidence Base

- Panelists agreed that better, evidence-based tools are needed for screening and detection.
- Evidence-based strategies for intervention and evaluation of these strategies are also needed (Dr. Sharps).

Screening

- Screening tools should be easy to use in busy clinical settings. Tools should account for the safety of the victim and proximity to the perpetrator during screening. Consider a multidisciplinary, emergency department–based elderly protection team to respond to potential cases of abuse or neglect (Dr. Rosen).
- Define the barriers to implementation of methods for screening and detection in order to build the best instruments (Dr. Carpenter).
- An attendee at the workshop noted that tools should include predictive analytics to assess efficacy.

Prioritization

- Increase expertise in abuse identification for study sections, IRBs, and journal reviewers (Dr. Carpenter).

Panel 2: Origins of Abuse, Early Adversity, Cycles of Abuse, and Abuse Across the Lifespan

Moderator: Marie-Therese Connolly, J.D. *(Senior Scholar, Woodrow Wilson International Center for Scholars)*
Panelists: Karl Pillemer, Ph.D.; Cathy Widom, Ph.D.; Sherry Hamby, Ph.D.; Sonia Salari, Ph.D.; XinQi Dong, M.D., M.P.H.

This panel integrated insights from research on child abuse and IPV with EA to consider common mechanisms and potential intervention targets. Ms. Connolly stressed the need for evidence-based interventions and publicly funded programs. She noted that the EA field is poised for progress and can learn from and collaborate with other fields that study violence (e.g., IPV and child abuse). The five panelists provided brief presentations related to their respective fields of expertise. Dr. Pillemer discussed the research needs in EA. Dr. Widom discussed lessons from child abuse research that may be applicable to EA. Dr. Hamby discussed poly-victimization and trends in violence research. Dr. Salari spoke about family violence across the life course. Lastly, Dr. Dong spoke about various forms of EA and violence across the life span.

Lessons Learned Related to Origins and Cycles of Abuse

Methodology

- Prevalence studies of EA in developed countries have already been established. Differences in findings reported in existing studies may be attributed to definitions and study design. New prevalence studies were not considered to be a high priority area for future research (Dr. Pillemer).
- Dr. Hamby argued that current prevalence studies are sufficient and asserted that more could be done to document the true burden of EA.
- Isolating different types of violence for separate study does not provide an accurate picture of the experience of abuse (Dr. Hamby). This type of analysis could inaccurately identify what is causing stress. Victims of multiple sources of abuse have the highest trauma scores.
- Risk factors for most types of violence, including EA, are the same (Dr. Hamby).

Policy

- Dr. Pillemer spoke against forced reporting, noting that this policy is not based on scientific evidence and that it could can have negative consequences for victims.

History of Abuse

- There is not strong evidence to suggest that child abuse is a part of the EA victim history (Dr. Widom).
- Data from a 30-year study funded by the Department of Justice support the notion of a cycle of violence for both sexes (Dr. Widom). The cycle of violence was also apparent in African Americans, but not in whites (based on arrest records).
- The number of arrests at the peak age range for violence is higher in people with a history of abuse or neglect (Dr. Widom). The data did not reveal an increase in violence in this group in the oldest age range, questioning whether this group is also at higher risk of EA.
- In studies analyzing victimization over the life course, physical violence (as opposed to other types of violence) is increased in the older age group of previously abused individuals compared to controls (Dr. Widom). The presence of a supportive partner appeared to decrease this risk.
- Patterns in family violence differ internationally, indicating that changes in policy could affect the prevalence of abuse (Dr. Salari).
- Patterns of IPV differ by age (Dr. Salari). In younger people, the violence tends to be homicidal, whereas in adults it tends to be primarily suicidal.

Prevalence

- Approximately 2.5% of the total population experiences physical or sexual abuse, yet these types of violence are the primary focus of abuse research and intervention.

Terminology

- Dr. Pillemer suggested that discussing EA in general terms should be avoided; it is overly generalized like the word “senility.”

Outcomes

- Child maltreatment experts disagree about whether physical, psychological, or sexual abuse produces worse outcomes (Dr. Widom). Some researchers aggregate all forms of abuse. Dr. Widom argued that there may be distinct health outcomes for subtypes of child abuse and that evidence supports intergenerational transmission of sexual abuse and neglect, but not of physical abuse.

Challenges Related to Origins and Cycles of Abuse

Evidence Base/Methodology

- No evidence-based treatment for EA exists (Dr. Pillemer).
- Family violence studies lack solid measurement methodologies (Dr. Salari).

- Data from the Population Study of ChINese Elderly (PINE) study indicate that prevalence data can be highly skewed based on the definitions or criteria used in a particular study (Dr. Dong). Risk factors have complex associations that appear to range widely by study.
- Dr. Dong urged caution in using current risk factors for guidelines and prevention. Exploratory analysis is needed.
- The current focus on demographics in EA is not a helpful approach to define interventions (Dr. Hamby).
- The inability to perform research on firearms and related injuries hampers the research repertoire (Dr. Salari).

Outcomes and Measures

- Dr. Hamby cautioned against comparing outcomes in different subtypes from different studies.
- Challenges of what to measure and how to measure it must be addressed (Dr. Jason Karlawish).
- Dr. Widom stressed the importance of the types of measurements used (self-report, official report, etc.) in data interpretation, noting that they can affect prevalence data. She said that cognitive impairment in EA is an additional challenge.

Causes

- Researchers must consider contextual factors, including race, ethnicity, gender, poverty, and neighborhood variables, to understand causes and consequences of EA (Dr. Widom).
- It is not clear why one type of violence emerges over another (Dr. Hamby).

Other

- Generational differences can affect the rate of disclosure about abuse (Dr. Salari).
- News reporting can include ageist assumptions that should be refuted (Dr. Salari).
- EA research is isolated from other forms of abuse research; it should be incorporated into poly-victimization studies (Dr. Hamby).

Opportunities for Exploration of Origins and Cycles of Abuse

Methodology

- Dr. Pillemer was moderately supportive of continued studies of risk and protective factors. He urged translational research to understand the science of interventions in EA.
- Study of poly-victimization, which includes bridging expertise and knowledge with other fields in the study of violence, neglect, and abuse, is a burgeoning area of science that will provide insight into relationships among the different types of violence (Dr. Hamby).
- Consideration of EA must go beyond caregivers and intimate partners (Dr. Hamby).
- There should be focus on prevention, protective factors, and resilience instead of dysfunction, with an emphasis on interventions targeting malleable interpersonal strengths.
- Progress in understanding the true burden of victimization and the resources needed to cope with adversity can be applied to older adults to improve health and well-being (Dr. Hamby).
- Subtypes of abuse must be considered (Dr. Dong). The general composite can mask positive and negative associations for different subtypes of abuse.
- Defining how incidents are problematic or harmful with severity indicators will help operationalize methods of assessment (Dr. Hamby).
- Methodology for working with the cognitively impaired would be useful (Dr. Lachs).
- Researchers and policy makers should expand the scope of who might be considered perpetrators of violence beyond family members (Dr. Kinkaid).

Risk Factors

- Isolation is a known risk factor that could be addressed with testable interventions (Dr. Salari).

Prevention

- Borrow and adapt from other fields of study of abuse to define prevention strategies for EA (Dr. Hamby).
- Opportunities for future research include (1) incidences of IPV that begin in the elderly; (2) prevention of abuse in patients with dementia, like Alzheimer's disease; and (3) programs that deal with mutual deviance (Dr. Pillemer).

Technology

- Wireless technology could be employed to monitor health and well-being and could empower families (Dr. Elwood). Another attendee noted that this approach could create privacy issues.

Recommendations/Needs in Origins and Cycles of Abuse

Methodology

- There is need for attention and resources to develop and test programs, treatments, and interventions to prevent elder mistreatment and to effectively treat the consequences of EA (Dr. Pillemer). These efforts would include randomized trials based on current scientific evidence using rigorous methods.
- There is need for prospective, longitudinal studies to understand cycles of violence (including both risk factors and protective factors; Dr. Widom). These studies challenge assumptions about relationships and help disentangle confounding variables.
- Analyze subtypes of EA (psychological, physical, financial, sexual, and neglect) because some markers might be protective for some types and a risk factor for other types (Dr. Dong, Dr. Widom).

Suicide

- Suicide should be considered a form of family violence because it can be strongly related to IPV (Dr. Salari).

Prevention

- Consider a shift in focus to strength-based approaches to empower the potential victim and understand protective factors in abuse (Dr. Hamby).
- Consider non-punitive prevention plans (Dr. Salari).

Funding/Infrastructure

- Create funding opportunities dedicated to EA research (Dr. Dong).
- Create networks or centers for researchers and clinicians to communicate and collaborate (Dr. Lachs).

Breakout Sessions Reports

Moderator: Marie-Therese Connolly, J.D.

A moderator from each breakout group provided a brief overview of the group's discussion.

Topic 1: Health Disparities and Cultural Dimensions of Abuse

Moderators: Scott Beach, Ph.D.; Lori Jervis, Ph.D.

Dr. Jervis stated that this session focused on populations that have been underrepresented in research.

Lessons Learned Related to Health Disparities and Cultural Dimensions of Abuse

- Very little is known about underrepresented groups experiencing EA.
- There are differences in history of abuse between African Americans and whites.

- The field of domestic violence research has adapted its services to particular cultural groups.

Challenges Related to Health Disparities and Cultural Dimensions of Abuse

- Funding levels.
- Creating definitions that capture cultural diversity and meaning of abuse in a specific cultural context.
- Finding measures that work across cultural groups (prevalence for these groups is also unknown).
- Accessibility of the population for recruitment; IRB issues.
- Imposing values of mainstream culture on other groups.

Opportunities in Health Disparities and Cultural Dimensions of Abuse

- Move away from a deficit perspective to a community-based, strengths-based perspective.
- Use community members as research collaborators.
- Acknowledge the core values of cultural groups and organize services accordingly (including tailoring and standardizing methods).
- Learn from the Resource Centers for Minority Aging Research, which provide a measurement and methods core.
- Dr. Hamby suggested identifying social markers that drive differences among groups.
- Dr. Kremer suggested that NIH consider adults with intellectual and developmental disabilities to be an underrepresented group.

Recommendations/Needs in Health Disparities and Cultural Dimensions of Abuse

- Recognize the value of qualitative research.
- Conduct longitudinal studies on EA within underrepresented populations.
- Derive measures that work across cultures.
- Conduct foundational research in underrepresented groups.

Topic 2: Preventing Mistreatment in Familial Environments

Moderators: Kerry Burnight, Ph.D.; Sonia Salari, Ph.D.

Dr. Burnight reviewed the summary for this breakout session, noting that the group focused on risk factors and not protective factors.

Challenges Related to Preventing Mistreatment in Familial Environments

- Operational vision in EA, as it relates to families, is lacking.
- Victims and perpetrators are hidden; measurement is difficult.
- The field is lacking information about causal mechanisms of perpetration (typologies).
- Outcomes of EA are not yet known or well defined.
- Unlike for child abuse and IPV, the "face" of EA is not well defined in society.
- Once in the system, almost nothing can help the situation for the perpetrator.
- Few interventions are available.

Opportunities in Preventing Mistreatment in Familial Environments

- Resources from a "focusing event" could be helpful to solidify public/political support.
- IPV: What police do at the scene matters. Incarceration is not helpful.

- Child maltreatment has excellent evidence-based prevention programs and long-term interventions for victims.
- Reconsider the U.S. policy of forced estrangement.
- Dr. Pickering suggested that researchers define what is and is not EA.

Recommendations/Needs in Preventing Mistreatment in Familial Environments

- Establish consistent source of funding for outcomes research and centers of research.
- Define interventions that work, which will require a cost analysis of intervention versus non-intervention.
- Look at victimization subtypes and poly-victimization.
- Consider community resources to support families.

Topic 3: Risk Factors: Diminished Cognitive/Decisional Capacity

Moderators: Jason Karlawish, M.D.; Daniel Marson, J.D., Ph.D.; Nathan Spreng, Ph.D.

Challenges Related to Diminished Cognitive/Decisional Capacity

- Identifying the point of contact for assessment of risk and proactive preventive intervention is difficult.
- The cost of interventions, particularly legal fees, is high.
- Ability to intervene requires a provider assessment.

Opportunities Related to Diminished Cognitive/Decisional Capacity

- Good conceptual frameworks exist, and well-validated assessments of decisional capacity have been developed.
- There are validated relationships and distinctions between cognition and capacity.
- Advancements in neuroscience may help define cognition, function, and capacity.

Recommendations/Needs Related to Diminished Cognitive/Decisional Capacity

- Provide education and training on assessing diminished capacity to a range of professionals who work with older adults.
- Study how social capacity changes and affects decisional capacity and risk of EA.
- Study how appreciation of impairment changes and what affects it.
- Understand the trajectories of decisional capacity and individual differences.
- Differentiate cognitive decisional deficits from other sources of deficit (e.g., sensory impairment, mood disorders).
- Develop and translate processes for professionals interacting with older adults when they suspect diminished capacity or abuse.
- Encourage researchers, particularly neuroscientists, to explore this field (e.g., funding stimulus).

Topic 4: Bioethics and Law in EA Research

Moderators: Miriam Kelty, Ph.D.; Mark Lachs, M.D., M.P.H.

Dr. Kelty explained that the discussion of Topic 4 covered scientific, legal, and ethical issues.

Challenges Related to Bioethics and Law in EA Research

- Capacity and other vulnerability issues must be addressed, balancing autonomy and the need to protect vulnerable groups.
- IRB issues include ethical and legal concerns on the part of IRBs and their institutions.
- Mandatory reporting requirements may create conflicts between protecting subjects and conducting research.
- Consider who is involved in discussions related to capacity for research participation and the legal/ethical issues of people who are potential victims of crimes.

Opportunities in Bioethics and Law in EA Research

- Support research on subjects with cognitive impairment and other frailties (Alzheimer's disease, intellectual disabilities).
- Consider inclusion of families in discussions, perhaps even perpetrators.
- Consider broadening the scope of providers who interact with the elderly for performing capacity assessment.

Recommendations/Needs in Bioethics and Law in EA Research

- Include victims and all involved stakeholders, including IRBs, in EA research.
- Communicate the importance of the problem of EA to a wide range of audiences.
- Create a community of researchers and practitioners in EA.
- Explore the possibility of guidelines for EA research with regard to IRBs.
- Establish centers to focus efforts related to EA.
- Ms. Connolly noted that the Elder Justice Act of 2010 mandated that the Department of Health and Human Services provide guidance on IRB issues; this has not yet happened.

Panel 3: Novel Intervention and Prevention Strategies

Moderator: Jeanne Teresi, Ed.D., Ph.D *(Director, Research Core, NYU School of Medicine)*.
Panelists: Elizabeth Skowron, Ph.D.; David Burnes, Ph.D.; Mary Ann Dutton, Ph.D.; Laura Mosqueda, M.D.

Dr. Teresi stated that goal of this panel was to discuss novel strategies for preventing abuse, mitigating its effects, and preventing recurrence. She reviewed the topics of discussion and questions to be considered, and she provided a brief overview of interventions and prevention in child maltreatment and IPV.

Each of the panelists spoke about intervention and prevention strategies. Dr. Burnes focused on direct response programs in the community, in practice, and in secondary prevention. Dr. Dutton reviewed strategies employed for IPV, and Dr. Skowron discussed lessons from child abuse research. Dr. Mosqueda reviewed needs for EA prevention strategies.

Lessons Learned Related to Novel Intervention and Prevention Strategies

General

- Knowledge from child maltreatment that might apply to EA include targeting those at risk, identifying parenting risk factors, screening, and using theory-driven interventions (educational, behavioral, home visits, embedding specialists, and technology; Dr. Teresi).

- Evidence suggests that effective parenting programs prevent child abuse (Dr. Skowron). Characteristics of effective programs include fostering positive, nurturing attachments; incorporating new knowledge of child development; building parent emotional competence; establishing strong social connections for parents and tangible supports for families; and involving intensive family involvement lasting longer than 6 months.
- Perpetrators of child abuse exhibit behavior that could be defined as self-regulation deficits (Dr. Skowron).

Methodology

- Identifying goals and their attainment helps to assess strategies.
- Current strategies use a best guess of risk and protective factors (Dr. Mosqueda).

Intervention Strategies

- Interventions in IPV include legal, medical, housing, training, and community services and prevention by life stage (Dr. Teresi).
- Malleable models allow for multiple scenarios, and interventions are tailored to the circumstances (Dr. Burnes).
- Community partners are essential for successful intervention strategies (Dr. Mosqueda).
- For IPV, reducing post-traumatic stress symptoms helps reduce revictimization by reducing avoidance (Dr. Dutton).
- In cases of domestic violence, arrest is an effective intervention that consistently shows a reduction in events. This is not true for child abuse; some of the data are based on national rates that differ by state. Dr. Salari noted that mandatory arrest policies for domestic violence have been rescinded because of unintended consequences.

Prevention Strategies

- There are successful strategies to prevent child abuse, including positive parenting programs (Dr. Skowron). There are few prevention plans for IPV, but the literature related to teen dating provides the most information (Dr. Dutton).

Challenges Related to Novel Intervention and Prevention Strategies

Intervention Strategies

- Dr. Teresi listed the following challenges with EA interventions: poor study design; few randomized, controlled trials; underpowered studies; poor measures; inadequate analyses; and poor compliance or response.
- Dr. Dutton reviewed lessons learned in IPV that may apply to EA:
    - Identifying the problem and education are necessary; screening alone can help reduce IPV.
    - EA and neglect within the family is a pattern of interaction that occurs within complex relationships.
    - Interventions that address the traumatic effects of abuse and neglect are important for victims and perpetrators.
    - Coordinated community response best practices are needed.
- With one exception, interventions are ineffective after child abuse has already occurred (Dr. Skowron).
- The interventions for EA are inconsistent nationwide, and none to date have been proven effective (Dr. Mosqueda).

Participation

- Underutilization of voluntary services is a challenge (Dr. Burnes).

- Outcomes sought by victims of IPV may not always be the outcomes sought by providers (Dr. Dutton).
- Enrolling people in EA research is difficult (Dr. Mosqueda). Motivational enhancement therapy reduced drop-out rates in child abuse studies (Dr. Skowron). Participation in IPV studies is a consistent problem. Dr. Dutton urged use of interventions with long-term support and voluntary participation.

Unintended Consequences/Secondary Prevention

- When an EA perpetrator is removed from the victim, the victim may not have other means of care and could be susceptible to self-neglect.

Technology

- Although electronic medical records may help capture information in the future, current versions are not sufficient for collecting research measures in a clinical setting.

Opportunities in Novel Intervention and Prevention Strategies

Methodology

- Research should explore participant engagement and intervention strategies (Dr. Dutton).
- Transition periods, or changes in life circumstance, could be times to employ prevention strategies. Caregiver training could be part of this endeavor.

Screening

- Screening may be an opportunity to educate people and reduce EA (Dr. Dutton).

Community Involvement

- EA research programs should include community-based services, multidisciplinary teams, and resident training (Dr. Teresi).
- Consider an integrated approach to prevention and intervention involving multiple community areas and systems (Dr. Dutton).

Intervention Strategies

- EA intervention should be targeted to the type of abuse, setting, characteristics, relationship, role, and culture (Dr. Teresi).
- Additional intervention opportunities include recognition, documentation, reporting, implementation, and action (Dr. Teresi).
- Although strategies should be individualized, there may be common issues to address (Dr. Burnes).
- Dr. Skowron is exploring the connection between parental physiological changes and parenting behavior to assess when a person's physiology is working with or against an intervention.
- As in child abuse, if the caregiver is related and stressed, perhaps implement EA interventions that facilitate and enable supportive caregiving (Dr. Skowron).

Prevention Strategies

- Promising prevention areas focus on self-awareness, regulation, and empathy (Dr. Hamby). The best outcomes include social and emotional learning.
- Social marketing campaigns can be effective, but only if the target audience is involved in the creation of the materials (Dr. Hamby).
- Bystander prevention could be an area of focus (Dr. Hamby).

Technology

- Technology may present an opportunity to enhance research participation and facilitate compliance, but researchers must be wary of overburdening the people performing the screening or intervention (Dr. Mosqueda).

Recommendations/Needs in Novel Intervention and Prevention Strategies

Methodology

- Use of rigorous measures for all EA research (Dr. Mosqueda). Strong measures of outcomes, including psychometric measures, are needed (Dr. Teresi).
- Prospective prevention studies in assisted living facilities and nursing homes may be warranted (Dr. Mosqueda). Longitudinal studies are needed.
- Goal attainment measures are needed to determine efficacy (Ms. Connolly). Goal attainment can be individualized, with an overall goal of risk alleviation that allows comparison across cases (Dr. Burnes).
- Strategies may need to be tailored for specific underrepresented populations, such as the cognitively impaired (Dr. Jervis).

Infrastructure

- Use of client-centered strategies that capture change and allow for heterogeneity (Dr. Burnes). Strategies should demonstrate feasibility, reliability, validity, and responsiveness.
- Infrastructure is needed to study EA, to create new models, and to assess their efficacy (Dr. Mosqueda). Dr. Mosqueda and others agreed that centers would be beneficial.

Closing Session: Summary of Discussion and Next Steps

Moderators: Mark Lachs, M.D., M.P.H.; Marie-Therese Connolly, J.D.

Dr. Lachs summarized the discussion and recommendations from the workshop related to screening, standards, and detection challenges, underscoring that cognitive impairment – a theme throughout the day – complicates so much of work in the field. He remarked on the rich insights that emerged from the session on the origins of abuse, early adversity, and cycles of abuse in families and across the lifespan, including the need to think about poly-victimization and the strengths-based approach (as opposed to an emphasis on risk factors). And he highlighted the potential for the elder abuse field to learn from successful interventions for victims of other forms of domestic violence. Ms. Connolly stressed that caregiving dependence, cognitive impairment, and ageism are challenges that elder abuse research and implementation strategies must combat. She also touted the potential of coordinated, multi-site centers or networks and harmonized data measures to advance work in this field. She thanked NIH for assembling people from diverse fields of expertise to explore the challenges and opportunities for combating EA, noting that this type of continued effort can be transformative.