Stress, Trauma, and Wellbeing in the Legal System

Edited by

Monica K. Miller

Brian H. Bornstein

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The Experiences of Older Adults in the Legal System

Edie Greene and Sheri C. Gibson

Between 2000 and 2010, the number of people in the United States under age 18 increased by 2.6%, and the 18 to 44 age group grew by a mere 0.6%. By contrast, the 65-and-older population increased by 15.1% (U.S. Census Bureau, 2011). By the year 2030, there will be 70 million older Americans, including almost 9 million people age 85 and older; the latter now constitutes the fastest growing segment of the U.S. population (U.S. Census Bureau, 2008).

Although one tends not to think of older adults as active participants in the legal system, their sheer number means that they will have increasingly important and visible interactions with the law in years to come. The elderly are already enmeshed with the legal system on issues as diverse as health care; end-of-life decisions; Social Security, Medicaid, and Medicare entitlements; estate planning, wills, trusts, and probate; cognitive impairment and guardianship; and elder abuse. A number of professional organizations address the legal issues of older adults, including the National Academy of Elder Law Attorneys (http://www.naela.org), the Center for Elders and the Courts (http://www.eldersandcourts.org), the National Center on Elder Abuse (http://www.ncea.aoa.gov), and the American Bar Association Commission on Law and Aging (http://www.abanet.org/aging).

In this chapter, we examine what psychologists and other social scientists have learned about the impact on older adults of involvement in three areas of the law: (1) as aging inmates in correctional facilities in the United States, (2) as victims of intimate partner and financial abuse, and (3) as individuals with impaired cognitive abilities involved in guardianship proceedings. We chose these issues because researchers and scholars have paid relatively more

attention to them than to other issues involving the elderly, although empirical scrutiny of capacity issues in the context of guardianship is still sorely lacking, as we note.

Older adults are generally not willing participants in the system—whether it is the correctional, criminal, or probate system. This fact enables us to discern the negative ramifications (as well as some positive outcomes) on individuals who are brought into the fold of the legal system involuntarily. It also allows us to assess the success of interventions developed to enhance the wellbeing of older adult prisoners, crime victims, and those with cognitive impairments and suggest possibilities for future policy refinement and revision. For the purposes of discussing the impact on older adults of involvement in the legal system, we occasionally use the terms *elder* and *elderly* where they seem most appropriate, recognizing the potential for derogatory undertones (American Psychological Association, 2010).

Incarceration

Inmate populations are growing older. In 2002, 8% of the total U.S. prison population was composed of individuals age 50 or older, nearly doubling the figure of the previous decade (Aday, 2003). Alarmingly, between 1995 and 2003, the percentage of growth in the population of inmates age 55 and older was larger than for any other cohort (Harrison & Beck, 2004). Women over age 50 constituted 12% of the female prison population in 1989 (Kratcoski & Babb, 1990), and the population of incarcerated women age 55 and older doubled between 1990 and 2001 (Harrison & Beck, 2002). This shift in the overall prison age composition will continue into the foreseeable future (Caldwell, Jarvis, & Rosenfield, 2001).

The "graying" of prisons is the result of two converging trends. First, prison inmates, like people who are not incarcerated, are tending to live longer. Second, sentencing practices of the past several decades have meant that vastly more offenders have received lengthy or lifelong sentences with little chance of parole. As a result, people who committed crimes when relatively young are aging in prison, developing chronic conditions and diseases of old age, and dying behind bars.

The increase in the number of aging prisoners is especially acute in California, where three-strikes laws mandate that offenders who are convicted of a third violent or serious crime must be sentenced to between 25 years and life in prison. Offenders eligible to be sentenced under three-strikes laws tend to be older than other inmates because they need time to accumulate two prior serious offenses. As a result, the population of California inmates over age 55 has increased 500% in the past 15 years (California Department of Corrections, 2007).

Ironically, aging inmates are far less likely to recidivate than their younger counterparts. According to national data, the recidivism rate for inmates

ages 18 to 29 is above 50% but is only 2% for those over 55 (Beck, Hughes, & Wilson, 2001). By the time people reach old age, the major sources of reinforcement for criminal activity (e.g., money, prestige, sex, power, settling disputes, righting perceived wrongs) have largely dissipated. And yet, elderly prisoners languish behind bars, at significant risk for health and psychological problems and at substantial cost to taxpayers. In this section, we describe some of the health and socioemotional issues that impact aging prisoners.

Effects of Incarcerating Older Adults

Health effects. Older inmates experience accelerated aging in prison, suffering from serious health problems at an earlier age than older adults in the general population (Yorston & Taylor, 2006). An inmate's physiological age averages 7 to 10 years older than his or her chronological age (Mitka, 2004). This stems in part from the already poor health history of impoverished inmates, a high prevalence of substance abuse, and lack of access to high-quality health care. But the stressors and rigors of incarceration also negatively affect inmates' physical and mental wellbeing.

Imprisonment results in low levels of self-care (Beckett, Peternelj-Taylor, & Johnson, 2003) that increase the incidence of serious health problems. Over the course of their lives, inmates have experienced higher rates of alcohol and substance abuse and addiction and a higher incidence of conditions related to risky behaviors (e.g., HIV/AIDS, hepatitis B and C, liver disease) than the general aging population (Linder, Enders, Craig, Richardson, & Meyers, 2002). A comprehensive review of 21 research articles on the health status of older inmates determined that the most commonly reported health issues were psychiatric conditions, cardiovascular disease, arthritis and/or back problems, respiratory diseases, endocrine disorders, and vision and hearing problems (Loeb & AbuDagga, 2006). Yet these conditions are also commonly reported by older adults in the general population. So what evidence exists that incarceration exacerbates or compounds the ailments of old age? Data come from three sources: information about health conditions that go untreated in prison, prisoners' self-reports on changes in their health status after being incarcerated, and a study that compared major illnesses recorded in medical records among elderly male prisoners, younger male prisoners, and community-dwelling older men.

Psychiatric disorders are the most common untreated condition in prisons. Rates of mental illness are high among prison inmates, and one study indicated that only 18% of older inmates with psychiatric diagnoses were given psychotropic medications. In contrast, 85% of elderly inmates with cardiovascular disease received medication for this condition (Fazel, Hope, O'Donnell, Piper, & Jacoby, 2004), indicating that mental illness often goes untreated.

Researchers have assessed self-reported changes in health in male inmates from a geriatric facility (mean age of 69 years) and a comparable group of younger inmates in the general prison population at the same correctional

institution (mean age of 51 years; Marquart, Merianos, & Doucet, 2000). Both groups rated their preincarceration health as good to excellent and reported declines in physical wellbeing after a 5-year period of incarceration. But data showed that the health of older inmates deteriorated faster than that of younger inmates, implying that the combination of imprisonment and advanced age contributes to declining health.

Perhaps the clearest evidence of the compounding effects of aging and incarceration comes from a study that compared medical records and reception health screenings of 233 male prisoners 60 years and older with the self-reported health status of 992 male prisoners ages 18 to 49 and 895 community-dwelling men ages 65 to 74 (Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001). The differences were apparent: 45% of elderly prisoners suffered from psychiatric disorders as compared to only 1% of community-dwelling elderly men (admittedly, this condition was likely underreported in the latter group); 35% of elderly prisoners had cardiovascular disease as compared to 3% of younger prisoners and 29% of community-dwelling older men; and 13% of elderly prisoners had genitourinary problems as compared with 1% of younger prisoners and 4% of community dwellers. In general, findings indicated high rates of morbidity in a population of older inmates and obvious differences in the health status of this population, a group of younger prisoners, and elderly men who are not incarcerated.

The psychiatric problems of elderly inmates merit special attention. It is widely accepted that long-term incarceration has negative effects on mental wellbeing, and several studies have documented the prevalence of psychiatric disorders in elderly male prisoners. For example, Fazel, Hope, O'Donnell, and Jacoby (2001) conducted diagnostic testing and interviewed 203 inmates (mean age 65.5) in correctional institutions in England and Wales. They also examined medical records to learn about major illnesses and current medications. On the basis of these data, they diagnosed depressive disorder in 30% of the sample and noted that only 12% were being treated with antidepressant medication. In an assessment of depression in a group of 121 male prisoners age 55 and over serving life or indeterminate sentences in English prisons, Murdoch, Morris, and Holmes (2008) found that nearly half (48%) of the sample scored above the mildly depressed threshold and an additional 3% were severely depressed. These rates of depression are higher than rates found in samples of younger inmates (e.g., Brink, Doherty, & Boer, 2001) and community-dwelling men of comparable age (Fiske, Wetherell, & Gatz, 2009). Surprisingly, Murdoch et al. concluded that the prevalence of depression was unrelated to the amount of time an inmate had been incarcerated or the length of his sentence but *was* related to physical health morbidity. The burden of chronic ill health seems to impact adversely on an elderly inmate's mood (or vice versa).

Fazel et al. (2001) also diagnosed personality disorder in 30% of their sample of 203 elderly male inmates. This rate is lower than that of a group of younger inmates (ages 18 to 65), 64% of whom, according to Singleton,

Meltzer, and Gatward (1998), had personality disorders. But it is higher than the rate of personality disorders in samples of community-dwelling older adults, with nearly all studies reporting prevalence rates ranging from 3% to 15% (Molinari & Segal, 2010).

Social and emotional effects. Given their lifelong experiences in criminal activity and advancing age, older prisoners historically had high status in institutional hierarchies. But with the influx of gang members in prison, older criminals no longer wield the power they once had and many experience or are fearful of victimization by younger, stronger inmates (U.S. Department of Justice, 2004). Fear of being victimized means that older prisoners may not exercise and may restrict their movements in other ways, leading to further isolation.

As inmates age or are separated from family and friends over an extended period, their social support tends to erode. Visitors are few, and letters and phone calls decrease and in some instances cease altogether (Lynch & Sabol, 2001; Travis, 2005). Some data suggest that isolation from outside support may be purposeful. According to a group of 80 prisoners ages 65 to 84 interviewed by Crawley and Sparks (2006), prisoners sometimes cut off contact in order to reduce their suffering and the suffering of others. One elderly inmate noted, "Prison life is more bearable and easier to cope with if you have nobody to care about beyond the walls" (p. 69). Yet many inmates with no hope of release described prison life itself as a lonely, almost unbearable struggle. Some of these men felt resentment that they were still imprisoned for crimes carried out more than half a lifetime before.

When questioned about the stressors that accompany long-term confinement, many prisoners identified the fear of physical and mental deterioration and the possibility (often, the reality) of dying in prison (Crawley & Sparks, 2006). Concerns about physical deterioration were most acute in those who suffered from chronic illnesses, given that access to immediate medical care in the prison—especially at night—seemed problematic at best. These men lived with intense fears of suffering a heart attack, stroke, asthma attack, or debilitating fall. Although nearly all interviewees expressed a dread of dying in prison, several inmates with life sentences articulated a deep desire to die in order to "escape." According to one: "Every night I hope I don't see the morning because there is no life for me. I am depressed 24 hours a day, and I know I'm going to die in prison. I hope I don't wake up..." (p. 74).

Perhaps the biggest concern of these elderly prisoners was their realization that, on reviewing their lives—most older adults look back over and reassess their lives at some point—they would see failures, missed opportunities, and botched relationships. Such a negative evaluation tends to fill people with regret, anxiety, and despair and makes the prospect of an impending death much more difficult to endure. According to Crawley and Sparks, this sense that time has run out makes an elderly prisoner's experience of incarceration vastly different from that of a younger inmate who still has "sufficient years left to try to re-make (and re-write) his life when he is released" (pp. 77–78).

Effects of incarceration on older women. The concerns of incarcerated older women differ in some ways from those of male inmates. Almost half of female inmates rated their health as poor or terrible, compared to only 12% of older men (Kratcoski & Babb, 1990). In prisons, older women have higher rates of comorbid conditions and greater use of medical care than men (Baillargeon, Pulvino, & Dunn, 2000). Older female prisoners experience higher rates of hypertension, asthma/chronic obstructive pulmonary disease, and arthritis than older women living in the community (Williams et al., 2006).

They also report high rates of functional impairment: 69% of geriatric female prisoners questioned by Williams et al. reported at least one impairment in prison activities of daily living (PADLs) such as hearing orders from staff, dropping to the floor for alarms, standing for head count, getting to dining halls for meals, and climbing on and off the top bunk. Functional impairment is associated with more adverse experiences such as falling, feeling unsafe, or being physically abused by other inmates.

Older female inmates also report a high need for privacy and safety, and many are intimidated by prison violence and the threat of violence. According to one inmate: "There are some older women who can't take care of themselves, so to be in a room with eight women and... with aggressive women is not a very safe place for them to be.... What happens is you see a lot of older women with black eyes" (Williams et al., 2006, p. 705).

Concerns about release. Although desirous of release, many of the elderly men studied by Crawley and Sparks (2006) were also anxious about that eventuality. In fact, only those with supportive families were enthusiastic about release. Prisoners without such support voiced concerns about how they would fare on the outside. They expressed worry about "starting from scratch," given that they had no relatives or friends, personal possessions, or housing. Understandably, some expressed the desire to simply stay put. "They had insufficient years left in life (or the energy) to 'start over'" (Crawley & Sparks, 2006, p. 75). Those with chronic medical conditions who had become dependent on some formal care from prison staff and on informal care provided by other inmates were especially concerned about access to health care upon release.

But tens of thousands of aging prisoners *are* being released every year (Williams & Abraldes, 2007) with significant psychosocial and medical needs that probation, parole, and health care agencies are ill equipped to handle. The stressors associated with adjustments to nonprison life are significant for nearly all former inmates but are especially problematic for older people. Some have lived behind bars for decades, others for more time than they have spent on the outside. They are often released into unsafe neighborhoods in which elderly, frail individuals are particularly vulnerable. Many lack family ties, employment and housing options, and financial resources. Significant medical and psychiatric needs and the stigma associated with having been imprisoned further compound their difficulties (Williams & Abraldes, 2007).

Analysis of Current Interventions

Given the multiple issues surrounding aging inmates, including their growing numbers and complex medical and psychiatric problems, various interventions have been implemented to address the issues. These include decarceration (releasing elderly inmates before their full sentences have been served), designing programming and housing to meet the needs of older prisoners, and developing hospice facilities within prison walls.

Decarceration. As prisons became overcrowded, corrections officials showed increasing interest in using scarce resources and space for high-risk offenders and selectively releasing, or decarcerating, inmates whom they consider to be a low risk to society. Because many older inmates tend to be both low risk and costly to house, and because most prisons were not designed to house inmates with limited mobility and chronic health problems, prison officials began transferring them to less expensive community-based programs including group homes, state nursing facilities, and congregate care institutions (Krebs, 2000).

Though unavailable to most prisoners, the Project for Older Prisoners (POPS) is a model re-entry program that identifies prisoners who have already served the average sentence for their offense, are deemed unlikely to recidivate, and whose victims have agreed to the release. Operating in five states (Louisiana, Maryland, Michigan, North Carolina, and Virginia) and the District of Columbia, the program assists older prisoners in transitioning back into the community. Evaluation data show that as of 2002, POPS had counseled more than 500 older inmates and assisted attorneys in winning the release of approximately 100, with no instances of recidivism (Rikard & Rosenberg, 2007). Another model, the Senior Ex-Offender Program, uses federal Office of Aging funding to provide housing, work opportunities, and financial, medical, and mental health services to newly released, older offenders (Williams & Abraldes, 2007). Data are needed on the effectiveness of the program to help offenders make a successful transition to living in the community.

Programming and housing to meet the needs of aging prisoners. Aging prisoners have different educational, recreational, and emotional needs and abilities than younger prisoners. Basic education courses should be paced more slowly, recreation programs should take into account the physical limitations of older inmates, and counseling programs should focus on issues of isolation, loss, and impending death, rather than on the rehabilitation and re-entry concerns of younger inmates. A number of programs now follow these dictates (Snyder, van Wormer, Chadha, & Jaggers, 2009), and some older inmates get programmatic assistance with Social Security, Medicare, and Medicaid applications and with writing wills.

As the population of older inmates has grown, some facilities have also begun to provide separate housing units that can accommodate wheelchairs and walkers, have wide aisles and handrails, and include assisted living areas and a central dining hall. Prison officials are divided on whether older inmates

should be integrated with or segregated from the general population of inmates (Rikard & Rosenberg, 2007). Some favor integration because they believe that older inmates have a calming effect on the general population and because integration allows better access to educational and vocational programs and to visitors (Yates & Gillespie, 2000). On the other hand, segregation minimizes safety concerns for older prisoners and allows them to forge support networks and friendships with people their age, reducing feelings of desperation and loneliness (Yates & Gillespie, 2000).

End-of-life issues. Though highly controversial, a few states have statutory provisions for compassionate release programs, sometimes referred to as medical parole, in which a dying inmate is released to a community health care facility or home care. In some states, an inmate whose health has improved must return to the correctional facility (Rikard & Rosenberg, 2007). More commonly, prisons rely on hospice programs to care for terminally ill inmates. Qualification requirements are the same as those in the community: a life-ending condition and a prognosis of 6 months or less to live. Hospice staff sometimes report that their services are at odds with the strict security procedures in place in most prisons (Granse, 2003). For example, corrections officers are often wary of prisoners' needs for medications to manage pain and continue to subject inmates to demeaning body cavity searches after visits to medical providers.

But some patient-friendly models of hospice care within correctional settings now exist; the program at the maximum-security unit at the Louisiana State Penitentiary at Angola is one example (Snyder et al., 2009). In this program, other inmates function as volunteers, and an unexpected salutary consequence is that in addition to filling in for absent family members and providing comfort to dying inmates, many volunteers have been transformed by those experiences. Other hospice programs ease prison rules for dying inmates by allowing extended visitations, honoring food requests, and providing different clothing.

Policy Recommendations

Given the significant problems of prison overcrowding and diminished state coffers, and the reality that elderly inmates tend not to recidivate, policymakers should be advocating for reform in sentencing statutes and the creation of alternatives to incarceration for older adult offenders. According to Krebs (2000), the time is right to reevaluate existing sentencing practices, including three-strikes laws that put people behind bars for life, statutes that require life sentences without the possibility of parole and that carry very long-term mandatory minimum terms, and laws that eliminate the possibility of granting early release for good behavior. Alternatives to prison include diversion programs for first-time offenders and house arrest and electronic monitoring programs that keep the offender in the community.

Inside prisons, staff should be trained to understand and address the unique needs of older inmates and to become knowledgeable about normal

aging processes. Simulated exercises that involve the use of glasses that blur vision, earplugs that reduce hearing acuity, and wheelchairs, walkers, and other props can increase empathy, and instruction on effective modes of communicating with the elderly can enhance staff interactions with older inmates (Snyder et al., 2009). Staff should be trained on the types of programming that will be accessible and useful to the elderly.

Finally, significant resources should be directed to re-entry and reintegration programs like POPS that benefit older adults. Community-based programs that historically have been unwilling or unable to accommodate older individuals with multiple health problems should be reformed. Day treatment centers, residential treatment programs, and nursing homes should be made available to recently released offenders, and social service agencies should be able to provide services and referrals of use to this population. Clearly, the need for trained professionals to work with older adults both inside and out of prison is essential, and just as obviously, resources to address these needs are lacking. Perhaps most obviously, as the cohort of baby boomers enters into the latter years of life, the problems associated with graying in prison will only become more acute, requiring that even more resources be directed their way.

Victimization

One consequence of increased longevity is a concomitant increase in the number of elderly people with frailties, chronic medical conditions, dementias, functional disabilities, and loss of decision-making capabilities. The erosion of social support and income that come with aging predispose the elderly to isolation and vulnerability. Elderly individuals who are isolated and no longer able to care for themselves or for their property are at risk of self-neglect, abuse, or exploitation by others.

Although elder mistreatment and victimization are not new phenomena, reported cases of elder abuse are increasing rapidly, and various studies have attempted to capture the size of the problem. In 1991, researchers estimated that 2.5 million Americans were victims of various forms of elder abuse, and by 1996, that number increased by 150% (National Center on Elder Abuse, 1998). Since that time, Adult Protective Services (APS), a social service agency responsible for investigating claims of elder abuse and neglect, has reported a 19.7% increase in elder abuse (Teaster, 2006).

The most recent report on prevalence rates of elder abuse comes from the National Elder Mistreatment Study (Acierno et al., 2010), in which 5,777 cognitively intact older adults provided self-reported data about frequency, type, and duration of abuse. Analyses revealed that 1 in 10 respondents reported some form or combination of physical, sexual, or emotional abuse or neglect occurring during a 1-year period. Over half of the respondents (55%) reported sharing a residence with the perpetrator, providing valuable information about the interpersonal complexities of elder abuse.

For many years, older adults silently tolerated these crimes, sometimes perpetrated by nameless criminals, but often by trusted caregivers and family members. Only within the last 25 years have elder abuse and neglect been given proper attention in policy circles and within the criminal justice system. It was not until 1993 that the American Medical Association published guidelines for dealing with the diagnosis and treatment of elder abuse and neglect victims (Aravanis et al., 1993). In this section, we explore the effects on elderly victims of neglect; intimate partner violence, a surprising and often misunderstood form of elder abuse; and financial abuse, an increasingly common form of elderly victimization yet largely hidden from public view. We briefly evaluate interventions and provide recommendations for further research.

Impact of Abuse and Neglect on Older Adults

Elder neglect. Elder neglect is defined as the "refusal or failure to fulfill any part of a person's obligations or duties to an elderly person" (National Center on Elder Abuse, 1998) and has been identified as the most common form of elder mistreatment in a domestic setting (National Center on Elder Abuse, 2005). The dependency of an older adult on a caregiver not only increases the vulnerability of the older person but also poses an environmental risk for neglect.

The caregiver stress theory, one model of elder abuse and neglect (Burnight & Mosqueda, 2011), posits that elder mistreatment and neglect occur when an adult caregiver assisting an impaired older person is unable to manage his or her caregiving responsibilities (Wolf, 2000). Due to the older adult's dependence on the caregiver, the caregiver becomes frustrated, overwhelmed, and abusive vis-à-vis the unremitting needs of the care recipient. Critics of the caregiver stress theory argue against this explanation because it places responsibility for abuse and neglect on the elder rather than on the responsible party (Brandl, 2002).

While caregiver stress has been linked to elder mistreatment and neglect, research has not shown that caregiver stress *alone* is a strong predictor of elder abuse (Hudson, 1986). Rather, it should be considered a risk factor that must not be overlooked (Burnight & Mosqueda, 2011). In a recent convenience sample of care recipients with dementia and their caregivers, 47.3% of the care recipients experienced some form of mistreatment, but only 29.5% experienced neglect by their caregiver (Wiglesworth et al., 2010). An earlier descriptive study of U.S. hospitalizations with elder mistreatment diagnostic codes revealed that the largest percentage (47%) of inpatient stays of adults age 60 and older was associated with a diagnosis of nutritional neglect (Rovi, Chen, Vega, Johnson, & Mouton, 2009).

Intimate partner violence. Intimate partner violence (IPV) is a serious problem affecting the wellbeing of millions of people (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Although more commonly reported in younger cohorts, this form of abuse is a significant concern for older populations given

their age-specific risk factors such as frailty and isolation (Krug et al., 2002). Intimate partner violence among older adults can be persistent throughout marriages or initiated by late-life changes or transitions that affect the relationship, such as a chronic disease or cognitive decline (Brandl & Meuer, 2000). In some instances, IPV can ensue with new relationships or second marriages (Brandl & Raymond, 1997), but in all cases IPV includes sexual, physical, and psychological abuse between two people in an intimate relationship. Risk factors for men and women who experience physical IPV include poor health, depression, substance use, and the development of a chronic disease, chronic mental illness, or injury (Coker et al., 2002).

Gender-biased assumptions that stem from feminist theories of power and control posit that women are always the victims and men always perpetrators (Dutton & Nicholls, 2005). But the empirical and theoretical literature on IPV in older age shows that women are as likely as men to be perpetrators (Reeves, Desmarais, Nicholls, & Douglas, 2007), and the belief that older women are not aggressors deleteriously impacts help-seeking behaviors in older men (Reeves et al., 2007). The implications for detection, assessment, and intervention in cases of IPV are far-reaching and require professionals to adopt new ways of identifying older victims and perpetrators.

Physical and mental health effects of intimate partner violence. As in other areas of elder victimization, there is scant understanding of the long-term effects of IPV among older adults. Identifying the long-term consequences of IPV is complicated by poorly defined terms of abuse, inconsistencies in research methodologies, limited screening and risk assessment instruments, and underutilization of health care diagnostic coding in U.S. community hospitals (Desmarais & Reeves, 2007; Rovi et al., 2009). Most research conducted on the physical and mental health effects of IPV includes small sample sizes consisting primarily of female victims.

The long-term health and psychological repercussions associated with *early* experiences of intimate partner abuse are somewhat better understood. These include depression, posttraumatic stress disorder, headache, irritable bowel syndrome, chronic pain, suicidality, and substance abuse (Campbell, 2002; Coker et al., 2002; Nelson, Nygren, McInerney, & Klein, 2004). In a poll of 995 partnered women over the age of 55 in primary care offices, Zink, Fisher, Regan, and Pabst (2005) found significantly higher rates of self-reported depression and chronic pain among IPV victims than nonvictims. Consistent with studies of younger victims (Campbell et al., 2002; Coker et al., 2000), Zink et al. found that older victims of IPV also had lower physical and mental health scores and more reports of digestive problems than nonvictims. Their findings support a growing need for additional training of physicians to recognize and inquire with sensitivity about comorbid symptoms that may be indicative of IPV among older patients.

Elder financial mistreatment. Elder financial abuse (EFA) is the illegal or improper use of an elder's funds, property, or assets. Examples include cashing a check without authorization or permission, forging a signature, misusing

or stealing money or possessions, coercing or deceiving a victim into signing a document (e.g., contract or will), and improperly using conservatorship, guardianship, or power of attorney. Some experts speculate that elders are ripe targets because they are more trusting and less sophisticated about financial matters than younger people (Kemp & Mosqueda, 2005) and relatively naïve about digital methods of handling financial transactions.

Whereas physical abuse and neglect can be more easily identified by those in medical and mental health fields, financial abuse is a difficult crime to detect. It leaves no physical mark, is largely hidden from public view, and typically occurs over years and in the context of family relationships that involve issues of entitlement and obligation. It is often difficult to distinguish from well-intentioned but misguided advice (Hafemeister, 2003; Rabiner, O'Keeffe, & Brown, 2006). Many older adults are quite unaware that it has occurred. Others hesitate to report because they are embarrassed or ashamed, lack understanding of protective and legal processes, are reluctant to inform on family members for fear of reprisal, or are concerned that reporting may lead to their loss of independence (Rabiner et al., 2006).

Most professionals who have contact with older victims (e.g., physicians, nurses, bankers, attorneys, mental health providers) have not been properly trained to recognize the signs and are not required to report the abuse (Quinn & Tomita, 1997). As a result, it is difficult to estimate the exact prevalence and incidence of such cases, although data from the National Center on Elder Abuse (2005) suggest that there may be at least 5 million victims of EFA per year.

A critical distinction between EFA and other types of financial crimes (e.g., fraud) is the close and trusting relationship between the elder and the exploiter, often a professional caregiver, family member, neighbor, or trusted professional. Although historically associated with child or spousal abuse, the concept of undue influence—the misuse of one's role and power to exploit the trust of another—also applies to EFA. Undue influence is typically accomplished by using subtle pressure and coercion to gain control over a weaker person's decision making (Brandl et al., 2007).

Older adults who are isolated, have cognitive impairments such as dementia, or are in a major life transition such as widowhood are particularly susceptible to undue influence (Choi & Mayer, 2000; Nievod, 1992; Quinn, 2000). For example, widowed women who were once accustomed to having financial affairs handled by a husband may find themselves trusting another (typically younger) man to assume that role. Widowers may fall victim to younger women posing in need of money in exchange for domestic chores and companionship (Nerenberg, 1996). In both scenarios, the perpetrator infiltrates the elder's home, preys upon his or her weaknesses, and consequently abuses the relationship for financial gain. Undue influence is not exclusive to nonfamilial caregivers; the situation is played out just as frequently among family members. In fact, the majority of reported cases of EFA have occurred between an elderly person and his or her adult child, grandchild, or other relative (National Center on Elder Abuse, 1998).

What Is Not Known About the Impact of Abuse

Because elder abuse is a largely hidden form of victimization, has been identified as a social problem only relatively recently, and is complex and multifaceted, the scope of the problem is just beginning to emerge. Difficulties in estimating incidence and prevalence are related to varying definitions and measurement techniques and to the lack of comparison groups in large-scale surveys (Lowenstein, 2009).

An understanding of cultural influences on abuse perpetration and on the reactions of victims is in its infancy. The issues include a differential focus among cultures on the individual versus the family and community, cultural variations in rights and privileges of females and males, and complexities related to culturally sensitive means of data collection and interpretation (Newman, 2006).

Information on the etiology of intimate partner violence is conflicting; some data suggest that aggression may be symptomatic of dementia because delusions of spousal infidelity are common in individuals suffering from dementia (Greene, Bornstein, & Dietrich, 2007; Mirakhur, Craig, Hart, McIlroy, & Passmore, 2004), and other data suggest that intimate partner abuse in old age reflects patterns of power dominance and control that were present throughout the relationship (Desmarais & Reeves, 2007). Scientists have yet to discern the circumstances in which each explanation applies, and without a thorough understanding of the causes of abuse, it is difficult to create solutions. Given the multifaceted nature of elder abuse, several theoretical explanations are likely to emerge (Connolly, 2010).

There is also sparse research on the formal and informal services and resources that older victims—particularly victims of intimate partner abuse—avail themselves of and whether they are well served by those interventions. Little is known about how abuser-focused concerns of the criminal justice system and victim-focused concerns of APS work independently or in combination to enhance victim safety and reduce reoffending. In some jurisdictions, if the police arrest an alleged abuser, APS will provide fewer resources to the victim, assuming that the source of the violence has been controlled; and if the police know that a case has been referred to APS, they are less likely to arrest and prosecute, assuming that the referral will effectively stem the abuse.

Finally, little is known about how courts can best accommodate elderly victims and perpetrators. The American Bar Association has recommended that prosecutors be given latitude in how they question older abuse victims, be allowed to film victims' testimony before capacity is lost or the victim dies, and be able to offer evidence from collateral sources, as is done in cases involving allegations of child abuse (American Bar Association, 2008). How fact finders will react to any of these practices is largely unknown.

Analysis of Current Interventions

Among the interventions currently in place or proposed to address the problem of elder abuse, three seem particularly noteworthy. These include

mandatory reporting, advancing state and federal responses to elder abuse as authorized by the Elder Justice Act, and developing elder abuse forensic centers that streamline responses to cases of suspected abuse.

Mandatory reporting laws. One reason that elder abuse is so rarely prosecuted is that many cases go unreported (Dessin, 2000; Hafemeister, 2003). Whether mandatory reporting increases the number of investigated and prosecuted cases is unclear, in part because of variability among states in the threshold for what constitutes abuse and who is considered a reporter. Some states mandate that any person with knowledge of abuse should report it, whereas other states require reporting only by persons with certain qualifications, and still others designate certain professionals as mandatory reporters.

In a survey of state officials from aging and APS agencies, less than 10% ranked mandatory reporting as the most effective way to maximize the number of elder abuse cases brought to the attention of authorities (U.S. General Accounting Office, 1991). Many respondents perceived that mandatory reporting laws do not directly influence the processing of valid cases but agreed that reporting requirements have led to additional resources and services.

Elder Justice Act. Enacted in March 2010, the Elder Justice Act (EJA)—part of the Patient Protection and Affordable Care Act—delineates plans to advance state and federal efforts to prevent and respond to elder abuse, neglect, and exploitation (National Health Policy Forum, 2010). Although appropriations have not yet been approved by Congress, several grant programs have been authorized by the EJA to fund state programs that emphasize training in detection and/or prevention of elder abuse and exploitation; enforcement of mandatory reporting requirements in suspected abuse in long-term care facilities; and the development of two elder abuse advisory boards to propose legislation on issues of elder abuse, neglect, and exploitation.

Elder abuse forensic centers. In response to an overwhelming increase in suspected cases of elder abuse and a decrease in state funding and resources (American Association of Retired Persons [AARP] Public Policy Institute, 2011), a new approach to investigating cases has been realized through the development of elder abuse forensic centers. Multidisciplinary teams consisting of professionals working within APS, law enforcement, long-term care, geriatric medicine, and neuropsychology have come together to collaborate on intervention. In 2003, California opened the first elder abuse forensic center, the Elder Abuse Forensic Center of Orange County.

In a recent examination of seven different multidisciplinary teams in California, all funded by the Archstone Foundation through its Elder Abuse and Neglect Initiative, Twomey et al. (2010) addressed the challenges faced by elder abuse forensic centers. These include issues of client confidentiality, cross-training of different disciplines, and group dynamics (Twomey et al., 2010). Some challenges were specific to managing complex cases of elder abuse. For example, team members from different mandatory reporting agencies and jurisdictions were challenged to navigate the elder abuse reporting system while learning about other disciplines' cultures, systems, and roles.

Complicated group dynamics prompted the development of "ground rules" for the Financial Abuse Specialist Team (FAST) in Solano County, which encouraged mutual respect for fellow team members and recognition of the challenges faced by their disciplines.

Despite these unique challenges, elder abuse forensic centers have largely been successful (Twomey et al., 2010). They play a critical role in increasing collaboration and efficiency among several disciplines in handling complicated cases of elder abuse, raising awareness and providing education through community outreach efforts, and protecting vulnerable adults from potential abuse.

Policy Recommendations

In her article "Where Elder Abuse and the Justice System Collide," Marie-Therese Connolly (2010) sets out recommendations for improving justice system responses to elder abuse. Given the comprehensive nature of these recommendations and for purposes of brevity, we list some of them here and recommend her article to readers who seek more detailed information. Connolly suggests the following: (1) form a national blueprint advisory committee to identify the most serious problems, promising solutions, and crucial next steps to redress elder abuse; (2) increase research and evaluation efforts; (3) develop theoretical models to explain elder abuse; (4) evaluate the effectiveness of mandatory reporting laws and criminal background checks to reduce elder abuse; (5) assess ways to prosecute cases when victim capacity is an issue; (6) evaluate, modify, and replicate successful multidisciplinary elder abuse forensic programs; (7) provide advocates to promote and maintain the wellbeing of victims through investigations and prosecutions; (8) train law enforcement, prosecutors, court personnel, and judges to recognize elder abuse and respond to it in effective ways; and (9) establish a clearinghouse of elder abuse resources.

Decision-Making Autonomy

Increased longevity also raises questions about what should happen when older adults begin to make decisions that are not in their best interest or that put themselves and others in danger, and how two core principles—autonomy and protection—can be optimized in responding to these issues. Psychologists and other clinicians address these concerns when they assess whether an individual has the cognitive and procedural skills necessary to function effectively in a particular domain. Moye and Marson (2007) identified eight major capacity domains that are relevant to older adults, including medical decision making and financial capacity.

Although most judgments about capacity are made in an informal manner by a network of family members, clinicians, attorneys, caregivers, and

social service personnel, capacity judgments sometimes become legal decisions made in an adversarial context by judges and informed by clinical assessments. This may occur when someone seeks to assume control over an elder's decisions (e.g., concerning driving) against the older person's will. It may occur when family members disagree about how best to care for an older adult who is believed or determined to lack capacity. In recent years, the large-scale transfer of wealth from the World War II generation to the baby boomer generation and the fragmentation of families have resulted in a marked increase in intrafamilial conflict about older adults' intentions and decisional capacity (Moye & Marson, 2007). Probate judges resolve these disputes.

The mechanism that the law has devised to deal with these issues is the establishment of guardianships and conservatorships by which judges appoint surrogate decision makers to handle the personal and financial affairs of the incapacitated elderly person. There are no federal laws governing guardianship; hence, policies and practices related to the duties and responsibilities of courts and guardians are determined by state regulations. In general, guardianship statutes are based on the doctrine of *parens patriae* that gives the government both the right and the duty to protect people who are no longer able to care for themselves. Thus, if a probate judge deems it in the best interest of the older adult or of society, the state may authorize surrogates to make decisions about an incapacitated person's care and protection, even over that person's objections (Grisso, 2003). In practical terms, guardianship can result in the loss of the right to make choices about living arrangements; health care; the purchase, use, or disposal of property; travel; making or revoking a will; getting married or divorced; spending money; and driving.

The National Health Interview Survey's 1995 Supplement on Disability (National Center for Health Statistics, 1999), a household survey of noninstitutionalized individuals in the United States, questioned adults age 60 and older (n = 13,784) about the factors associated with having a guardian (Reynolds, 2002). Those factors included having a small family network (additional family members decreased the probability of having a guardian by 42%), not living with a spouse (living with a spouse decreased the probability of having a guardian by 58%), and having functional impairments, confusion, disorientation or forgetfulness, and Alzheimer's disease. The decreasing size of families and increasing rate of divorce among future cohorts of older adults foreshadow the important role of guardianships in the future.

What Is Known About the Effects of Guardianship on Older Adults

Personal control enhances life satisfaction among the elderly (Berg, Hassing, McClern, & Johansson, 2006; Kunzmann, Little, & Smith, 2002; Langer & Rodin, 1976), and many older adults want to maintain their own authority for making decisions for as long as possible. According to one survey, they desire to have "the last word" about their care (Boisaubin, Chu, & Catalano, 2007).

Some evidence suggests that wards have felt angry, resentful, agitated, and upset by guardianship proceedings and the removal of decision autonomy (Bulcroft, Kielkopf, & Tripp, 1991).

Yet many adults who are made wards of guardians probably fare better with some assistance than they would without (Moye, 2003). Empirical evidence on surrogates' ability to represent the health care preferences of elderly and disabled people showed that surrogates can enhance the chances that the best interests of the other person are taken into account (Shah, Farrow, & Robinson, 2009), although a meta-analysis on how accurately surrogates can predict patients' end-of-life treatment preferences showed that predictions were incorrect in one-third of cases (Shalowitz, Garrett-Mayer, & Wendler, 2006).

The value of guardianship was made apparent by interviews of a random sample of 50 individuals under guardianship in Los Angeles County (Wilber, Reiser, & Harter, 2001). The interviews documented high levels of confusion and significant limitations in interviewees. When asked how they felt about their guardianship arrangements, 40% indicated that they did not understand or remember that they had appointed guardians. When one interviewee "learned" from the interviewer what guardianship/conservatorship entailed, she responded, "I'm sure I would not like that." Twelve percent of interviewees expressed satisfaction with their guardians, whereas 24% had lingering reservations and concerns, including the possibility that assets would be depleted and the ward placed in a skilled nursing facility.

On the basis of their data, Wilber et al. concluded that the most severe impact on the wards was not the appointment of a guardian per se, but rather preexisting impairments and problems (e.g., a long-standing psychiatric disorder, physical limitations, cognitive impairment) that probably resulted in the provision of protective services in the first place. These data imply that although there is some lingering distrust and confusion in a significant minority of cases, the appointment of a guardian to make decisions on behalf of an incapacitated elderly person can yield satisfactory outcomes in a large number of cases.

What Is Not Known About the Effects of Guardianship on Older Adults

It is difficult to assess how at-risk older adults under guardianship compare with similar individuals without guardians on measures of longevity, physical and emotional health, and self-reported wellbeing, and equally difficult to quantify the costs of removing autonomy on wards who are not seriously incapacitated (Wright, 2010). With the exception of a unique early study in which researchers randomly assigned older adults who were incapable of self-care to an experimental group that received a variety of medical, financial, legal, and social services or to a control group that did not (and found negligible differences between the two on measures of survival, contentment, and functional competence; Bleckner, Bloom, Nielsen, & Weber,

1974), researchers have been unwilling or unable to conduct studies of this sort because of concerns related to denying care to those in need. As a result, questions still loom about the effects of the loss of autonomy on wellbeing.

Based on her experiences representing elders in guardianship proceedings and borrowing the concepts of therapeutic jurisprudence, Professor Jennifer Wright has provided a comprehensive and nuanced analysis of the putative therapeutic and antitherapeutic effects of guardianship on the wellbeing of respondents and wards (Wright, 2010; for further discussion of therapeutic jurisprudence, see chapter 2, this volume). Although her observations may hold up to empirical scrutiny, as yet the rigorous research that can systematically examine her suspicions is lacking. Still, her analysis provides an exceptionally clear blueprint for moving the field forward and elucidating the real consequences of intervention in the lives of older, infirmed adults.

Wright suggests that there are many negative implications of guardianship, including the fact that because medical and social service personnel pressure families to take protective action, painful discussions between family members and elders with diminishing capacity are shut down. The all-or-nothing adversarial nature of guardianship proceedings results in a hardening of positions among family members, attorneys, and respondents that does little to further compromise. She also suggests that guardianship hearings demean and shame the respondent because he or she must listen to others testify about the loss of decision-making ability and difficulties related to self-care. This cruel public portrayal of the infirmed older adult can, according to Wright, lead to loss of self-esteem and serious depression. Finally, Wright opines that a contested guardianship proceeding can fracture family relationships, result in a ward feeling hostile and resentful toward the guardian, and reduce the likelihood that treatments that might slow or reverse the decline are sought out.

Wright also offers a litany of putative therapeutic effects, including the possibility that the filing of a petition will force the older adult to confront the realities of the situation and discuss, perhaps for the first time, the need for additional care. These conversations can help elders to understand the high costs associated with their insistence on self-sufficiency, both for themselves and for care providers. Wright also suggests that the petition for guardianship is often the catalyst for a series of physical, mental, and functional assessments that can lead to treatments or other accommodations to enhance safety and comfort. Finally, in the best of circumstances, guardianship proceedings can enable older adults to speak on their own behalf and, when supported by counsel, experts, and other witnesses familiar with the situation, to feel empowered by the experience. Although Wright articulates these possibilities in a compelling and reasoned way, most of her observations still await empirical confirmation.

Analysis of Current Interventions

Clearly, some older adults are so incapacitated and lacking in functional abilities that they would be unable to care for themselves or their assets under

almost any independent living situation or structured financial arrangement. For these individuals, a formal or informal transfer of decision-making powers is imperative. Short of this extreme, some assistance in bill paying and money or asset management can keep an older adult solvent and protect his or her estate. Attention to the physical aspects of one's environment (e.g., wheelchair access, potential hazards) can also enhance the chances of successful independent living.

Simply changing some aspect of an individual's environment may provide sufficient support to allow that person to continue to function independently and make his or her own decisions. In these situations, remedies short of full guardianships (e.g., case or care managers, durable powers of attorney for property or health care, living wills, community advocacy systems, and money management programs) are appropriate. Indeed, there is growing pressure on probate judges to move away from full guardianship that rescinds decision making in a wide variety of domains and, instead, to appoint surrogates to narrowly constrained tasks (e.g., making decisions about driving or medical treatment; National Guardianship Network Members, 2004). As capacity assessment improves, clinicians will be increasingly able to suggest alternatives to guardianship that support independent living, and judges and other legal professionals will be increasingly able to tailor their interventions to the specific needs of a particular individual (Moye & Marson, 2007), with the ultimate goal to maximize both autonomy of the elderly and protection of those who are most vulnerable.

Policy Recommendations

In her thoughtful analysis of the guardianship system, Wright (2010) also suggested ways to reshape the system to maximize the therapeutic effects of intervention and minimize its antitherapeutic consequences. She borrowed two concepts—problem-solving courts and mediation—from other contexts and proposed ways they might fit into guardianship reform (for more on the therapeutic component of problem-solving courts, see chapter 2, this volume). She suggested that rather than focusing on the traditional litany of questions such as whether the respondent is legally incapacitated, whether a guardian is needed, and who the guardian should be, problem-solving courts would ask about the underlying reasons that the parties entered into guardianship proceedings and how various medical, social service, and counseling providers could work with the parties to reach a solution that is acceptable to all.

Since 1991, the Center for Social Gerontology, a nonprofit research, training, and policy institute in Ann Arbor, Michigan, has been conducting field research of various guardianship mediation programs that involve the use of trained, neutral facilitators to work with disputing parties to resolve conflicts related to protective intervention (Butterwick, Hommel, & Keilitz, 2001). Although lacking a rigorous study that randomly assigns some cases to mediation and others

to traditional probate court proceedings, the center has ascertained that participants believe mediation can be effective in reaching satisfactory resolutions and are generally satisfied with their experiences. Whether this reform is a practical alternative to traditional proceedings and whether it can address some of the presumed negative effects of those proceedings await further study (see chapter 13, this volume, for more on alternative dispute resolution).

Although both of these reforms offer attractive ways to resolve immediate problems and improve the wellbeing of petitioners and respondents in the short term, the fact that many mental faculties typically continue their downward slide suggests that they may not be cost-effective solutions for the long term. Empirical research will be needed to assess the viability of each.

Conclusion

As the population of older adults grows, elders' involvement in the legal system will increase as well. A variety of issues—only a few of which we have elaborated on in this chapter—bring them into contact with the law: loss of capacity, entitlements, abuse and neglect by caregivers and "trusted" others, age discrimination, estate planning and probate, health care reform, disability rights, and end-of-life decisions. Many older prisoners have been "in contact with" the law for decades. In this admittedly selective analysis, we have documented that a large number of elderly prisoners, unlikely to recidivate and costly to taxpayers, are languishing behind bars waiting to die in prison. We have also shown that older adults are increasingly likely to be victimized, often by relatives and friends who prey on victims' declining faculties, and that these declining capabilities raise concerns about how to optimize both self-determination and protection in old age. We have discussed the ability of mental health professionals to assess decision-making capacity, as well as the willingness of guardians to make decisions on behalf of vulnerable older adults with diminished decision-making capacity.

Each of these situations demands unique and nuanced responses, predicated on knowledge of the physical and psychosocial determinants of aging and the complexities of elder law. This will obviously require infusions of resources to support research, training, and advocacy efforts and to develop innovative ways to enhance elders' involvement in the legal system. Time will tell whether those resources will flow. The need is surely present.

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