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Abuse among the Hispanic elderly : a service provider perception

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ABUSE AMONG THE HISPANIC ELDERLY

A SERVICE PROVIDER PERCEPTION

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"SI SE PUEDE" *

If your mind can conceive it and your heart can believe it, then you can achieve it.

This Research Project is respectfully dedicated to my husband, Abel, for the many times he ate alone. To my children, Abel and Jeanne, who reassured me that I could do it. To my friend, Marianela Reategui, for her financial and moral support. To my friends from SFC Mexican Catholic Organization, for being there when I needed a shoulder on which to cry. To Faculty and friends from the School of Social Work, especially Nicky Rivas, who encouraged me. To my good friend and co-typist, Millie Katemopoulos, for her innumerable hours of typing and for her faith in me. To Stephanie Tryon, for teaching me to drive. To Mae Silhanek, for believing in me. To Helen Hansen, for giving me the opportunity to find out that, "SI DE PUEDE", IF YOU BELIEVE IN YOURSELF.

* Note: "Si se puede" means: Yes, we can do it.

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CHAPTER I

INTRODUCTION

It has only been in the past ten years that the topic of elder abuse began to emerge in professional circles. Prior to 1970, no guidelines for assessing elder abuse existed. Referral resources did not exist, nor did adequate literature to educate the professionals around issues of intrafamily violence situations, i.e., domestic violence, child abuse or elder abuse. The moral ethic of family privacy was a dilemma for the researchers who began to focus on the family violence field. Most of the studies were exploratory and based on mail survey, case studies, and a combination of personal interviews with secondary data analysis (Douglas & Hickey, 1983).

Presently, elder abuse is a well documented problem and a variety of protocols and laws are available to identify elder abuse. However, little or no research has been done to guide professionals to increase their awareness of specific variables that may be involved in a specific case of abuse of the Hispanic elder.

The Hispanic elder, who has been a victim of abuse, exploitation, or neglect is often confused or physically dependent. Usually he/she lacks the physical or mental capacity to take care of his/her own needs. No accurate mechanism presently exists to determine the number of individuals who are frail elderly. The chances of being

defined as "frail elderly" increase with every year of age, if the individual has a physical or mental disability (Beck and Phillips, 1983).

The House Select Committee on Aging survey identified twenty-six states which have some type of protective services for the elderly. The provisions and services vary with each state according to the State Legislation. Some states may provide services under general health and welfare laws but the states also vary as to whom the laws apply. The underlying premise is that when the abuse is reported, most of the abuse has been done by a member of the family, because the abuser is under stress. In these cases, education for the elderly on their therapeutic rehabilitation, and support for the caregiver, may be the safety valve for the built-up tension which may have resulted in the abuse (Quinn and Tomita, 1986).

According to workers in the field, stress in the family does play a big role in elder abuse. Intervention such as counseling and finding support for the family can in some instances end the abuse. One of the new support systems presently available for families and the elderly is The Adult Day Health Care Center concept which provides therapeutic rehabilitation for the elderly as well as respite for the caregiver. Unfortunately, there is only one such Center in Santa Clara County for the Hispanic elder. Legislation has been proposed at the federal level which

would provide more federal funding to increase the number of Adult Day Health Care Centers.

As a society, both federal and state efforts need to be directed specifically toward encouraging the development of Adult Day Health Care Centers to provide support to the family in caring for the elderly members and preventing physical abuse but, most of all, to prevent the psychological abuse of the elderly. The elder who shows no black-and-blue marks consequently goes undetected. With the increase in Adult Day Health Care Centers, the state will be able to provide the elderly with the therapeutic treatment their prognosis requires, and the caregiver with the respite time that will minimize the stress so that they will continue taking care of the elder more successfully.

The review of literature has shown that there has been some research on the nature, extent and causes of elderly abuse (Giarano and Giarano, 1984), but minimal research on abuse among the Hispanic elderly. If service providers are to reach the Hispanic elderly, additional research into the correlation of service providers' perceptions of the Hispanic population and the specific values they share as a group, will be necessary.

The purpose of this study is to determine (a) the level of training service providers have in relation to elder abuse; (b) the awareness that service providers have of transcultural practice when working with the

Hispanic elderly; and (c) the service providers' attitudes and perceptions when he/she sees the abuse occurring within a Hispanic family.

Within this exploratory study, in order to collect data on reported cases of Hispanic elder abuse, personal interviews were conducted with service providers. Subjects were asked about their perceptions of elder abuse within the Hispanic population, their awareness of cultural issues and the need to develop transcultural skills to assist the Hispanic elderly and the caregivers when symptoms of elder abuse appear.

In addition to the difficulty of research in this sensitive field, the writer is aware of other limitations of the study: (a) concentration on service providers in Santa Clara County; (b) different levels of training within the service provider group; and (c) the small number of service providers available for this study. Due to the particular focus on service providers in Santa Clara County, it is important not to generalize to a broader population because the sample was not a representative one.

A. DEMOGRAPHICS OF ABUSED HISPANIC ELDERLY

Although there is a growing awareness and concern regarding abuse among the elderly in our society, the abuse, neglect and exploitation of the elderly is an increasing problem in our nation. Why is this such a complex and difficult growing problem? Perhaps because our society has a hard time believing that anyone would abuse or harm an elderly person.

The Hispanic elder not only experiences the same status of being abused as other elderly population, but is also faced with the disadvantages of poverty status and the frequent inability to communicate fluently and effectively in English.

The elderly are a sizeable segment of our society. The 1980 census showed a 15% increase in the number of elderly. Thus, nearly 35 million people in this country are now in the elderly group.[1] From this group, nearly 709,000 are of Spanish origin, which represents about 3% of all older Americans.[2] Unfortunately, as the senior population grows, so do the number of crimes against them. The House Committee on Aging indicates roughly that 4% of the nation's elderly are victims of abuse, which is about one out of twenty-five elderly people. The Sub-Committee on Health and Long-Term Care found that if all elderly abuse cases were reported, one out of every twenty-five

of all elders are abused in some way.[3] The primary targets are the fragile high risk elderly, usually those who are ill and dependent upon others for their care and well being.

B. DEFINITION OF TERMS

The Encyclopedia of Social Work states the difficulties in defining terms in social work. The writer explains the frustration over the task of selecting an acceptable terminology for a field in which uniformity is uncommon and cultural changes are rapidly altering ways of work. This project uses the following operational definitions:

WHAT IS AN ATTITUDE?

The American Heritage Dictionary states attitude is a posture or manner of caring for oneself. For this study, an attitude is the state of mind the social worker brings to the client based on previous experiences working with the Hispanic.[4]

WHAT IS A PERCEPTION?

For the general public, a perception is the result of becoming aware of a situation through the senses. For this project, perception is an impression the social worker has developed while working with the Hispanic population, a feeling of alertness for their special needs. (The American Heritage Dictionary, 1982).

WHAT IS LIFE EXPECTANCY?

Butler and Lewis define life expectancy as the statistical prediction of how long an organism will live beyond a given initial age.[5]

WHAT IS A CAREGIVER/CARETAKER?

Beck and Phillips described a caregiver/caretaker as the person who expends time, energy and resources in interacting and caring for an elderly person.[6]

WHAT IS TRANSCULTURAL?

Transcultural practice is a conceptual framework for understanding the process of an individual experience when going from one's own cultural set of values to a new "imposed" set of values represented by the dominating group.[7]

WHO IS A FRAIL PERSON?

Frail persons are frequently seen as incompetent, thus unable to make decisions about their own lives, childlike, in need of protection, and only consumers of services. However, a frail elderly is a person unable to care for him/herself due to mental or physical condition and who needs a comprehensive array of health and/or social services in a protective setting.[8]

WHAT IS A SERVICE PROVIDER?

A service provider is a professional or para-professional person in direct work contact with

individuals, groups, or communities, which entail specific skills to administer to the needs of individuals, with the intent of improving the welfare of those individuals.

WHAT IS ABUSE?

The United States Department of Health and Human Services describes abuse as a violation of a person's rights. The four categories the Department presents to describe elder abuse are:

1. Physical - Hitting, beating, restraining unnecessarily by tying to a bed or chair, forcing unwanted sexual activity.
2. Psychological - Verbal assault and threats, isolation, infantilizing, relocating against their will.
3. Exploitation - Financial abuse, such as theft, misuse or appropriation of the elder's money, property or possessions.
4. Neglect - Withholding or failing to provide an adequate level of care.[9]

WHO IS AN ELDER?

In the past, the image of the elderly represented an individual with wisdom in its many connotations, including knowledge, understanding, maturity, good judgement, experience, skills, etc. Presently, there are no clear answers to the question of when a person is considered old. For this youth-oriented society,

an elder is a person who has reached a certain age and has no identifiable task, work or family role. Robert Butler and Myrna Lewis said, "Old age, then, is a multiple determined experience that depends on an intricate balance of physical, emotional and social forces, any one of which can upset or involve others".[10] For others, who must rely on the federal law to determine old age, the task is not evenly defined. Under Social Security, the minimum old age is now sixty-five years. The Department of Housing and Urban Development uses sixty-two years of age to determine if an individual is eligible for subsidized elderly housing. The Department of Labor Employment projects fifty-five years of age for an individual to qualify for Title V Program (A job training for the elderly). Hispanic life expectancy is 56.7 years in comparison to 73 years for Caucasians. (Butler and Lewis, 1982). This study defines an elderly as a person who is fifty-five years and over.

WHO IS A HISPANIC?

According to the Bureau of the Census (1981), it is estimated that approximately 9.2 million persons living in the United States identified themselves as being of Hispanic origin. This group

of people is classified into five major categories: 1) Mexican-Americans, 2) Puerto Ricans, 3) Central and South Americans, 4) Cubans, and 5) Others. Although there are variations among the five groups, they share common values and cultural attitudes.

Also, general characteristics, which can be found among the Hispanic groups include:

- Orientation toward persons, rather than toward ideas or abstractions;
- Commitment to individual's family with the context of familiar and traditional Hispanic values;
- Emphasis on the central importance of the family;
- Emphasis of being, rather than doing;
- Emphasis on the father as main authority figure.[11]

WHAT ARE THE CHARACTERISTICS OF THE HISPANIC ELDERLY?

As a group, the Hispanic elderly share many common characteristics and concerns. The most common concerns are: coping with rapid inflation, escalating health care cost, rising costs and scarcity of housing. In addition, the individualized difficulty in requesting government services due to language and cultural barriers and discrimination. Carmen Lacayo, Director of Asociacion Nacional Pro-Personas Majores, said: "Our Nation has made considerable progress in improving the quality of life for older Americans since the White House Conference on Aging in 1951. But, in many respects,

we seem to be going backwards today. In 1980, poverty increased by 32,000 for elderly Spanish origin persons."[12] She also presented the main characteristics of the Hispanic elderly as:

- They have a much shorter life expectancy; a smaller proportion of Spanish origin population is 65 or older.
- They live in poverty. By 1980, almost 31% of all Hispanic Elderly were living in a state of poverty. (Poverty is defined, on a weighted basis, as having income below $3,941 for a single person, and $4,954 for an elderly couple, in 1980.)
- Poverty is specially widespread among older Hispanic women who live alone or with non-relatives.
- They are functionally illiterate. Average education level among the Hispanic elderly is 5.7 years.
- They share common values and cultural attitudes. Hispanic elderly resent being told they are inferior, when their ancestors, the Mayans in Peru, and Aztecs in Mexico, founded sophisticated civilizations centuries before the Spanish or the English dominated their culture.

Mexicans are a group in the Hispanic category, and knowing that the framework of values used by Mexicans can be applied to help any other Hispanic group, the researcher would present the family values the Mexicans practice as a group, as follows:

- Mexicans have a close family system, reflected in their belief that family problems have to be resolved within the family, or by someone who has gained that family's acceptance.
- They practice the extended family role as a support system.
- The role of the individual family member is in family decision-making. In general, the father is the provider, the head of the house and the decision-maker. The mother is primary caregiver, responsible for the children's welfare. The oldest son is the third most important person in the family. He is expected to take his place as the head of the house in the absence of the father. The role of the daughter is to be the obedient child, to be the mother's helper and, for the oldest, to care for and to be a good example to the younger siblings. (Valle, 1974 Valle Mendoza, 1983).

Although abuse, neglect and exploitation occur in a broad cross-section of the elderly population, the Hispanic elderly can be an easier target for exploitation due to their unfamiliarity with the English language. In addition, the vulnerability of the Hispanic women, who are used to being dominated, makes them a higher risk target. These problems are frequently intensified for the widowed, because they tend to be weaker and more gullible. In a very real sense, they experience triple jeopardy because they are old, poor and Hispanic. "This barrier compounds the difficulty that older Spanish-origin persons encounter in cutting through government red tape to receive their benefits."[13]

CHAPTER II

REVIEW OF LITERATURE

Because American society has been and continues to stereotype the process of aging, the transition to old age is viewed as a physical and mental decline, accompanied by economic insecurity, and rigidity of personality. These negative attitudes toward old people may advance the potential for elder abuse. In addition, the experts present the following factors:

A. MAJOR FACTORS ASSOCIATED WITH ELDERLY ABUSE

There are many factors which contribute or may be the causes of elderly abuse. One of them can be the economic need of the abuser and the victim. The situation of an elderly person living with the family or their offspring creates a risk of abuse with the most well-intentioned child. The elderly person generally has a low income and cannot afford to live by him/herself (Center for Older People said that, in the range of 65 years to 112 years, the larger number are women, and the majority are widows). At the time the elderly person moves in with the son or daughter, she may be mildly sick or disabled. Increasing disabilities or illness of the mother may force the caretaker to give up a job. If the income of the two workers was needed to maintain the family income, this new financial situation will bring an extraordi-

nary amount of stress to the family, resulting in abuse to the person who supposedly has created the problem, both economically and functionally.

Barry Lebowitz, who heads the Center of Studies of the Mental Health of the Aging, worries that families will be seen as large-scale dispensers of abuse. "I'm not one to say that all family care is good care,"[14] says Lebowitz. "But it certainly is significant: an estimated 60 to 80 percent of long-term care in the community is provided by kin."[15]

In the late 1970's, a state-funded survey was conducted in Massachusetts and showed that elder abuse as well as other types of abuse pervade American families. Since then, projects and surveys conducted on the subject agree that the elder is likely to suffer both physical abuse and neglect. The victim is oftentimes a widow who depends on her caregiver because of some kind of impairment, and the caregiver/abuser is usually middle-aged with various kinds of pressures and often addicted to a drug (Giordano & Giordano, 1984).[16]

Patterns of family interaction also play an important part in the development of abusive relationships. One pattern that often leads to elder abuse is found in families in which the abuser has suffered real or perceived mistreatment by the parent earlier

in life. In this case, the personal relationship the abuser and the abused may have had in the past may cause the conflict. If the family has a history of violence as an acceptable method of relieving anger and frustration, the action of beating may be seen as "normal" to the abuser. If, in addition, there are unresolved past conflicts between the persons (when the caregiver was growing up), abuse is even more apt to occur. (Quinn and Tomita, 1986)[17]

Dr. Jannet Mickish states that another contributing factor of elder abuse is stereotyping of the aged supported by our society and, in particular, mass media. Very often, age is used to evaluate an individual; his/her qualities come next. The way society views old people contributes to potential elder abuse. It is noted that "society views older people as socially, psychologically, and physiologically isolated, restricted and deteriorated. Old people are characterized as non-productive because they absorb goods and services but do not replenish the supply".[18] (Mickish, 1985)

An old English rhyme gives voice to a man who remembers living with his grandmother, who beat him when he was a boy. The rhyme continues: "Now I am a man and I live with my granny and do to my granny

what she did to me."[19] (Anonymous)

Society, including those of a Spanish-speaking origin, perceives grown children as the logical group of people to accept the responsibility of caring for their own elderly relative without really checking to see if the person is the most qualified for the task. With so many diverse and conflicting values, automatic acceptance by children for the caring of the elderly relative cannot and should not be assumed as a good solution for the elder's needs.[20] (Valle Mendoza)

Lebowitz found in his study on families caring for an elderly, a correlation between the caretaker and the motives for assuming the caregiver's role. He or she, Lebowitz said, may resent having to care for a parent who needs care and has no support when there are other members of the family who can share the job, but they are not doing it.[21] The present caregiver may have taken the responsibility for the wrong reasons and not for the solid purpose of helping the older parent. It may have been the social pressure coming from the generalization that the "Hispanics take care of their own",[22] religious feelings of sacrifice of oneself, or with the assumption that the rest of the family would share the responsibility, and no one does. If, at the same time, the caregiver has a crisis of her own, she is

more likely to alleviate her frustrations by abusing the elderly parent in her care.[23]

In 1973, Linda R. Phillips conducted a study of 74 frail homebound elderly. She discovered that some elderly received less than satisfactory care from their families. The study was conducted over three consecutive years in a clinical setting. The subjects were frail elderly, ranging in age from 62 to 95.

The nurses were to provide a short report about the subjects and were also requested to fill out the "Abuse Report Form (ARF) (2)". The problem was that after the abuse was presented, few alternatives were available to relieve it, and those few did not offer adequate protection for abuse from related caretakers.

Abuse to the elderly can be there, even though there is no evidence of blatant violence, if the caregiver is an alcohol or drug abuser. In assessing Mrs. R., she seemed passive and withdrawn, saying, "I always give in to John, especially when he is drinking. If I am meek and humble, he will like me, so I just stay in my room when he is drunk."[24] This assessment resulted in a psychiatric diagnosis of psychological abuse and high risk for physical abuse of the mother. There is documented evidence that a person with a drinking problem or drug abuse is more likely to withhold or fail to provide

adequate level of professional or personal care to the elderly under their care.[25] (Quinn and Tomita, 1986)

When an elderly parent moves into the adult child's home, or vice versa, individual personalities must be adjusted to each other. Family members may find that attention and resources are now allocated in a different way to each family member, creating stress and the need for further adjustment in a probably already stressful family situation. In one particular case, the problem began with a letter from a son to his mother: "Dear Mom, I know life is tough for you in Miami, after Dad's death. I cannot stop thinking of you, all by yourself, but boy, it is tough here in California, too. Consequently, I have a great idea! You sell your home there and come out here to live with us. You can use the money to build an apartment in our property, and if you can help us with the rent, you can live here, and we will take care of you the rest of your life." Unfortunately, the mother lived longer than her son's marriage, so when her son was divorced, the house was sold. The money was split between the son and the daughter-in-law, and the mother was placed in a residential care home paid by the Welfare Office.[26] (U.S. Senate Committee on Aging, 1981)

The Legal Research and Services for the Elderly

in Massachusetts found several problems in dealing with elder abuse cases:

- The victim rarely reports the abuse.
- Access to victims are difficult. If the victim is living with the abuser, the abuser can block entry into the home. Depending on the State Adult Protective Services Law, the police may have no more rights in these cases than the case worker.
- Even if access can be gained, the victim will not often admit the problem or seek help.
- The victim usually lives with the abuser who is normally family or caretaker.
- The victim believes that little or nothing can be done. Getting a non-consenting victim to change to consenting can take weeks, month or years.
- The abused elderly needs flexible and multiple services, and most programs are neither.
- The abuser frequently has a drinking problem or is in need of other type of counseling for which the mental health system lacks services.
- Abuse occurs over a period of time, and crisis intervention does not help when working with a history of family violence or long-term problems, such as alcoholism and drug dependence problems.[27]

When the elderly person experiences a loss of control or may sense a loss of usefulness, productivity,

independence, or mobility, he/she may lose contact with friends and peers. Within the system, this elder can have a homemaker, but, because of the lack of professional homemakers who want to work for a minimum salary, social workers call upon the relative to be the caretaker, without checking on their habits.[28] (Mickish, 1985)

Dr. David Staats and Dr. Diana Koin presented the factor that poor self-image by the caregiver increases the likelihood of elder abuse. They stated that a limited capacity to express personal needs makes these persons psychologically unprepared to meet the dependency needs of an elderly parent. This situation is more often seen when the incapacity is coupled with a denial of their parent's illness.[29]

The role reversal may create power struggles within the family. Although there are few studies on adjustment of roles, the early role of the elderly person as the head of the house may bring conflict with the younger homemaker. The elderly mother may feel that her experiences in child disciplining and decision-making are better than those of the younger homemaker. In this situation, the participants are generally not ready for this power structure, creating a potential setting for violence.[30] (Mickish, 1985)

In some cases, a caregiver is also growing old. The expectations of relief and relaxation after the children are grown and have moved away, are destroyed with the new situation created by an ill parent. The problem becomes even more frustrating as the parent grows older, as very often, the elderly parent becomes increasingly dependent, sick, incontinent and fragile. If, at this time, sleep deprivation and fatigue appear, the potential for elder abuse increases.[31] (Staals and Koin)

B. POSSIBLE INDICATORS OF ABUSE:

The East Bay Elder Abuse Prevention Consortium describes possible indicators of elder abuse as follows:

. Possible Indicators of Physical Abuse:
. Cuts, lacerations, puncture wounds
. Bruises, welts, discoloration
. Any injury compatible with history
. An injury which has not been propertly cared for, normally covered by clothing
. Loss of weight with no medical condition
. Absence of hair or hemorrhaging below scalp
. Burns: may be caused by cigarettes, caustic acids, friction from ropes or chains[32]

In describing possible indicators of financial abuse, the Consortium present the following indicators:

. Unusual or inappropriate activity in bank accounts
. Signature on checks or other papers that do not resemble the older person's signature.
. Power of attorney given, or recent changes of will, when the person is incapable of making such decisions.
. Unusual concern by caregiver that an excessive amount of money is being expended on the care of the older person.

- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder.
- Placement in nursing home or residential care facility which is not commensurate with alleged size of estate.
- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the estate can well afford.
- Recent will when the person is clearly incapable of making a will.
- Missing personal belongings such as art, silverware or jewelry.[33]

Regarding possible indicators of abuse from the caregiver, the Consortium stated these indicators:

- The elder may not be given the opportunity to speak for him or herself, or to see others without the presence of the caregiver and suspected abuser.
- Attitudes of indifference or anger toward the dependent person, or the obvious absence of assistance.
- Family member or caregiver "blames" the elder (e.g., accusation that incontinence is a deliberate act).
- Aggressive behavior (threats, insults, harassment) by caregiver toward the elder.
- Previous history of abuse to others.
- Problems with alcohol or drug abuse.
- Inappropriate display of affection by the caregiver.
- Flirtatiousness, coyness, etc., as possible indicators of inappropriate sexual relationship.
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit by the caregiver.
- Inappropriate or unwarranted defensiveness by the caregiver.
- Conflicting accounts of incidents by the family, support or victim.
- Unwillingness or reluctance by the caregiver to comply with service provider in planning for care and implementation.[34]

The Consortium presented the possible indicators of neglect by caregiver as:

- Elder is inadequately clothed.
- Elder is malnourished or dehydrated.
- Elder is in soiled clothing or soiled bedding.
- Elder has untreated medical condition.
- Elder has rashes, sores, lice.
- Elder has dirt, fecal/urine smell, or other health and safety hazards in his living environment.[35]

Also, the Consortium presented the following attitudes and behavior patterns as possible indicators of psychological/emotional abuse:

- Fear
- Denial
- Agitation
- Anger
- Depression
- Helplessness
- Hesitation to talk
- Implausible stories
- Confusion or Disorientation
- Withdrawal

In addition, Adult Protective Service Program states that any service provider who observes or otherwise obtains information causing them to suspect elder abuse is encouraged, and in some cases mandated, to report the abuse.[36]

CHAPTER III

METHODOLOGY

RESEARCH DESIGN:

The areas of elder abuse among the Hispanic population has not been studied previously. This exploratory study has been designed to gather data about the variables of that elder abuse as perceived by the service providers.

The researcher's personal experiences and interest in working with the Hispanic elder for many years, as well as the sources of information identified in early chapters, are the bases for the writer's precise research question to be answered by this study. The question is:

What are the attitudes and perceptions of service providers in Santa Clara County on elder abuse among Hispanic families?

SUB-QUESTIONS:

1) Is violence an outcome of hierarchical characteristics often found in Hispanic families?
2) Is elder abuse common among the Hispanic population?
3) In what socio-economic group does elder abuse most commonly occur?
4) Does the increase of substance abuse (alcohol and/or drugs) among the younger generation appear to have caused an increase in elder abuse?
5) When elder abuse among the Hispanic occurs, is the

abused persons likely to report the abuse?

6) What type of abuse more commonly occurs?

7) What are the demographic characteristics of the abused elder?

DATA COLLECTION:

For the purpose of this study, a hundred (100) service providers from Santa Clara County were selected. Fifty-seven out of the 100 providers participated in the study. The agencies surveyed included: Department of Social Services, Adult Protective Services, East Valley Clinic, Gardner Health Clinic, Centro De Bienestar, Casa Macsa, Veterans Administration, The Bridge, Catholic Charities, O'Connor Hospital, Good Samaritan Hospital and The Council on Aging.

The service providers were surveyed with a questionnaire prepared by the author (See Appendix A). Sixty questionnaires were collected for the study and have been compiled, tabulated and analyzed. The data analysis, frequency distribution and cross-tabulation was accomplished by the use of CRISP. The time frame for the survey was from March 1, 1987 through April 1, 1987.

Interview schedules used in this study were sometimes presented by the director of the programs to the service providers in their staff meetings. This form of participation was chosen over a face-to-face questionnaire because of the highly confidential nature of the subject matter.

RESEARCH INSTRUMENT:

The instrument utilized in this study consisted of twenty-five (25) questions, submitted to each service provider for response. It was a newly developed instrument and was pre-tested upon a group of sixteen respondents. Three questions were modified as a result of pre-test. The items in the questionnaire consisted of both fixed and three open-ended questions.

The questionnaire collected four categories of data: demographics, service provider's knowledge of the Hispanic community, and service provider's attitude and perception on: abuse in the families, abuse in the Hispanic families and abuse to the Hispanic elder.

Questions numbered 1, 2, 3, 4, 5 and 6 represent demographics and knowledge of the Spanish language of the service providers.

Questions numbered 16, 17, 18, 19 and 20 assess the service provider's perception related to abuse among the families in general.

Questions numbered 9, 10, 11, 13 and 14 measure the service provider's knowledge of the Hispanic community.

Attitudes and perceptions of the service providers on elder abuse are investigaged by questions 8, 12, 22, 23 and 24. Given the dilemma to interpret open-ended questions in a sensitive field, the responses were summarized by the author in as objective a manner as possible.

LIMITATIONS OF STUDY:

It is important not to generalize the results of this study for the following reasons. In the first place, the sampling used consisted of a purposive, non-representative sample. Secondly, the sample size is too small to enable these results to be generalized. The selection of service providers from Santa Clara County limited generalizations only to this area. The possible bias of the researcher in the interpretation of the last three open-ended questions may also represent a limitation.

Despite these limitations, it is believed that this study may provide direction for further research. The data collected will provide the service providers with a better understanding of the occurrence of elder abuse among the Hispanic community. In addition, this study can also be used as a base for other studies when examining the same problem among other minority groups.

RESEARCHER'S BACKGROUND:

This researcher has spent the last thirteen years working in the field of Gerontology. During the last seven years, the researcher has held a position as Geriatric Case Manager with responsibility for services to the Hispanic community. The researcher has also done considerable work with abusive children and abused parents.

In addition to expertise developed during work at Santa Clara County Health Department, American Cancer Society, Veterans Administration, Valley Medical Center and Catholic Charities, the researcher has spent considerable time researching elder abuse and abuse in general due to her personal interest.

CHAPTER IV

RESULTS

A total of fifty-seven service providers were interviewed for this research project. The participating agencies are: Santa Clara County Mental Health Programs, Department of Social Services, East Valley Clinic, Gardner Center, Centro De Bienestar, Casa Macsa, Veterans Administration, Visiting Nurse Association, The Bridge, Catholic Charities, O'Connor Hospital, Good Samaritan Hospital and The Council on Aging. All participating agencies provide services for the Hispanic elder.

First, demographic information was analyzed and presented. Secondly, the responses collected from the questions of the survey were interpreted. Trends concerning subject's apparent knowledge of abuse in the families were reported. Abuse within the Hispanic families and abuse to the Hispanic elder were also discussed. Thirdly, the results were presented in four sections: Part 1 presented the knowledge of the Spanish language among the service providers; Part 2 described the service provider's perception related to abuse among the families in general; Part 3 related their knowledge of the Hispanic community; and Part 4 reported the service provider's information about elder abuse and the significance of their perception.

DEMOGRAPHICS OF SERVICE PROVIDERS:

The selected subjects were professionals or para-professionals providing direct services for the Hispanic elder. Out of the fifty-seven (57) total population sample, fourteen (N-14 or 26%) were from the medical field, thirty-one (N-31 or 57%) were from the social work field and three (N-3 or 5%) were from others.

The levels of education ranged from 8th grade to college education. Of the 57 respondents, thirty-five (N-35 or 61%) were post-grad, thirteen respondents (N-13 or 23%) had one year plus of college and nine respondents (N-9 or 16%) had less than high school education. Table 1 illustrates this data.

Table 1
Distribution of the Level of Education of the Service Providers by their Number

Levels of education	No. of Subjects	Percentage of Sample
Less than 12 years	9	16%
1+ years of college	13	23%
Post-grad	35	61%
Missing Data	None	

(Note: Statistics on 57 observations with non-missing data.)

The reported areas of professional concentration of the service providers are identified in Table II: sixteen participants (N-16 or 28%) were from Gerontology; eight participants (N-8 or 14%) were from Administration; two participants N2 or 4%) were from Mental Health. In addition, three participants (N-3 or 5%) were from Nutrition, three respondents (N-3 or 5%) were from Nursing, eight participants (N-8 or 14%) were case managers, and one (1%) reported the legal field. Two providers (N-2 or 4%) were also from Adult Protective Services and ten participants (N-10 or 18% reported to be in the Health field (not in Nursing). Data was missing for four of the respondents. Table 2 illustrates the data related to the question above.

Table 2
Distribution of the Professional Concentration of Service Providers by their Number

Area of Concentration	No. of Subjects	Percentage of Sample
Gerontology	16	28%
Administration	8	14%
Mental Health	2	4%
Nutrition	3	5%
Nursing	3	5%
Case Management	8	14%
Legal	1	1%
Protective Services	2	3%
Health	10	18%
Missing Data	4	

(Note: Statistics on 53 observations with 4 missing data.)

The participants responded about their experience working with the Hispanic elder in the following manner: forty-six (N-46 or 82%) of the respondents stated working with the Hispanic elder. Ten participants (N-10 or 17%) answered no. There was only one (1%) individual who did not answer the question. Table 3 presents the data summarized above.

Table 3
Distribution of the Provider's Experience
Working with Hispanic Elder by their Number

Worked with Hispanic Elder	No. of Subjects	Percentage of Sample
Yes	46	82%
No	10	17%
No Answer	1	1%
Missing Data	1	

(Note: Statistics on 56 observations, 1 missing data.)

When the respondents were asked about their ability to speak Spanish, forty individuals (N-40 or 70%) answered yes, seventeen respondents (N-17 or 29%) answered no. There was no missing data. When inquired as to their levels of fluency in the Spanish language, twenty-nine participants (N-29 or 71%) claimed to speak fluently, seven individuals (N-7 or 17%) stated speaking very little, one answered Spanish-speaking with difficulty, four participants (N-4 or 10%) stated being bicultural, and sixteen individuals (N-16 or 28%) did not answer the question. Table 4 reports the data in response to the question above.

Table 4
Distribution of the Level of Spanish Fluency
by the Number of Service Providers

Spanish Level	No. of Subjects	Percentage of Sample
Fluently	29	71%
Very Little	7	17%
With Difficulties	1	1%
Bicultural	4	10%
Missing Data	16	

(Note: Statistics on 41 observations, 16 missing data.)

In addition, the participants were asked as to their years of experience working with Hispanic elderly. The answers were: thirteen participants (N-13 or 28%) had less than two years' working experience; fourteen participants (N-14 or 30%) had two to five years experience; eight participants (N-8 or 17%) had five to seven years. Six individuals (N-6 or 13%) had nine to eleven years. Another six individuals (N-6 or 13%) had eleven plus years and ten (N-10 or 18%) did not answer this question.

PERCEPTION OF SERVICE PROVIDERS ON FAMILIES IN GENERAL:

Discussion of Research Questions:

Is Abuse an Accepted Norm Within a Particular Family?

The respondents were asked five questions related to their perception on abuse within a family in general. The first question asked was, "If abuse does occur in a violent situation, is violence an accepted norm within that particular family?" In response to this question, twenty-four (N-24 or 43%) answered yes. Ten individuals (N-10 or 18%) answered no. It is significant to note that twenty-two participants (N-22 or 40%) answered unknown. Only one individual did not respond to this question.

The next question was, "If, and when, abuse does occur, by whom is it initiated?" The answers were: Thirty-three participants (N-33 or 65%) answered that abuse is initiated by a relative. Six participants (N-6 or 12%) answered, by the caregiver. There were five participants (N-5 or 10%) who answered, by the spouse. Four individuals (N-4 or 8%) who answered, by the son. Another three participants (N-3 or 6%) answered, others. Six individuals (N-6 or 11%) did not answer the question. Table 5 reports on the question stated above.

Table 5
Individuals Perceived as Initiators of Abuse
by the Number of Respondents

Who Initiates Abuse?	No.of Subjects	Percentage
Son	4	8%
Spouse	5	10%
Caregiver	6	12%
Relative	33	65%
Others	3	6%
Missing Data	6	

(Note: Statistics on 51 observations, with 6 missing data.)

There were two questions that specifically asked the use of drugs or alcohol related to abuse. One question was: "If, and when, the abuse occurs, is there the existence of alcohol abuse?" To this question, twenty-two participants (N-22 or 50%) answered, sometimes. Only one participant answered no, and twenty participants (N-20 or 46%) gave a definite yes. Table 6 reports these data.

Table 6
Distribution of the Perceived Association of Alcohol to Abuse by Number of Respondents

Alcohol related	No. of Subjects	Percentage
Yes	20	46%
No	1	2%
Sometimes	22	50%
No answer	13	22%

The other drug-related question was: "If, and when, the abuse occurs, is there the existence of drugs (e.g. cocaine, marijuana, etc.)?" The answers were: twenty-one participants (N-21 or 55%) answered yes. Three participants (N-3 or 8%) answered no, and Nineteen participants N-19 or 33%) did not answer this question. See Table 7.

Table 7
Distribution of the Perceived Existence of Drugs Related to Abuse by Number of Respondents

Drug Related	No. of Subjects	Percentage
Yes	21	55%
No	3	8%
No Answer	19	33%

(Note: Statistics on 24 observations, 19 missing data.)

PERCEPTION OF SERVICE PROVIDERS ON THE HISPANIC COMMUNITY

Discussion of Research Questions:

In what Hispanic groups have you seen elderly abuse?

Questions number 9, 10, 11, 13 and 14 asked service providers as to their perception on the Hispanic families in relation to abuse.

With respect to question 9 on their perception of abuse equality among all the Hispanic groups, the answer was: four participants (N-4 or 8%) answered yes, fourteen participants (N-14 or 28%) answered no, thirty-one participants (N-31 or 62%) answered unknown, and eight participants (N-8 or 14%) did not answer the question. See Table 8.

Table 8
Distribution of the Number of Respondents
by their Perceived Abuse of Equality Among Hispanics

Providers Opinion	No. of Subjects	Percentage
Yes	4	8%
No	14	28%
Unknown	31	62%
No answer	8	14%

(Note: Statistics on 49 observations and 8 missing data.)

The next question was: "Is there a socio-economic group within the Hispanic community in which its occurrence is more frequently noted?" To this question, eleven providers (N-11 or 22%) answered yes. Seven providers (N-7 or 14%) answered no. A big majority of thirty-three (N-33 or 65%) answered unknown, and six participants (N-6 or 11%) did not answer this question. See Table 9.

Table 9
Distribution of the Number of Subjects by their Perceived Existence of Abuse Among Special Hispanic Group

Providers Opinion	No. of Subjects	Percentage
Yes	11	22%
No	7	14%
Unknown	33	65%
No answer	6	11%

(Note: Statistics on 51 observations and 6 missing data.)

When providers were asked to define a specific socio-economic group, the question was: "If yes, in what group is the abuse more frequently noted?" The answer to this question was: Eleven providers (N-11 or 33%) answered low-income. Four providers (N-4 or 13%) answered middle-income. Sixteen providers (N-16 or 53%) answered all. Twenty-seven (N-27 or 47%) did not answer this question. See Table 10.

Table 10
Distribution of the Number of Subjects by their Perception of Abuse in Specific Socio-Economic Hispanic Group

Providers Opinion	No. of Subjects	Percentage
Low-income Class	10	33%
Middle-income Class	4	13%
All Classes	16	53%
No Answer	27	47%

(Note: Statistics on 30 observations and 27 missing data.)

Question thirteen asked service providers for their opinion of the Hispanic families as being violent. The question was: "Is there the existence of violence among the Hispanic family?" The answer was: thirty-one providers (N-31 or 54%) answered yes. Two providers (N-2 or 4%) answered no. Twenty-four (N-24 or 42%) answered unknown, with no missing data. Table 11 illustrates these data.

Table 11
Distribution of the Number of Subjects by the Opinion of Providers as to the Existence of Violence Among Hispanics

Providers Opinion	No. of Subjects	Percentage
Yes	31	54%
No	2	4%
Unknown	24	42%

(Note: Statistics on 57 observations, and no missing data.)

Table 12
Distribution of the Number of Subjects by Provider's Opinions about Hispanic Group in which Abuse is More Noticed

Providers Opinion	No. of Subjects	Percentage
Mexican-American	13	43%
Puerto Rican	1	3%
Chicanos/Mexicans	11	37%
South/Central Americans	5	17%
No answer	27	47%

(Note: Statistics on 30 observations and 27 missing data.)

To identify the group within the Hispanics where abuse is more common, the following question was presented: "If, yes, in what group is it more frequently noticed?" The answer was: thirteen participants (N-13 or 43%) answered Mexican-American, one participant (N-1 or 3%) answered Puerto-Ricans, eleven participants (N-11 or 37%) answered Chicanos-Mexicans, five participants (N-5 or 17%) answered South/Central Americans. There were twenty-seven participants (N-27 or 47%) who did not answer this question. Table 12 above illustrates these data.

The analysis of these data shows that most professionals or para-professionals working with the Hispanic elder may be unprepared to detect violence within the Hispanic families. For example, 27 respondents did not answer the question. It is important to notice that of the ones that answered, 80% agreed that Mexicans, Chicanos and Mexican/Americans are the most violent group within Hispanics.

SERVICE PROVIDERS PERCEPTION ON ELDER ABUSE:

Respondents were asked for discussion of research question : Is elder abuse common within the Hispanic Community?

In reference to the above question, three open-ended questions were presented to research the service provider's awareness of variables involved in elder abuse within the Hispanic Families. The findings were: For question number eight which asked, "In your opinion, is it common for the abuse of the elderly to occur within the Hispanic Community?" The responses were: sixteen respondents (N-16 or 29%) answered yes, twelve respondents (N-12 or 22%) answered no, twenty-six respondents (N-26 or 48%) answered unknown and three respondents (N-3 or 5%) did not answer the question. Table 13 illustrates these data.

Table 13
Distribution of the Perceptions of Providers as to How Common Is Elder Abuse within the Hispanic Community by the Number of Subjects

Providers Opinion	No. of Subjects	Percentage
Yes	16	29%
No	12	22%
Unknown	26	48%
No response	3	5%

(Note: Statistics on 54 observations and 3 missing data.)

With reference to service provider's own opinion regarding elder abuse in general, and elder abuse within the Hispanic elderly community, more specifically, two open-ended questions elicited responses indicating that financial problems, alcohol and drugs abuse, and stress of the caregiver were the leading causes for elder abuse. The distribution was as follows: Question number 23 asked, "In your own opinion, what are the most frequent precipitating factors of abuse?" The answer was: ten providers (N-10 or 24%) answered financial, nine providers (N-9 or 23%) answered alcohol or drugs, another nine providers (N-9 or 23%) answered stress of any type (without specifying reason of stress or of whom?). Five providers (N-5 or 12%) answered caregiver's burnout. Three providers (N-3 or 7%) answered lack of support from other family members. Two providers (N-2 or 4%) answered language barrier and one provider (N-1 or 2%) answered woman working. See Table 14.

Table 14
Distribution of the Number of Subjects by Provider's Opinion as to Identified Factors of Elder Abuse in General

Provider's Opinion	No. of Subjects	Percentage
Financial	10	24%
Alcohol or drug abuse	9	23%
Stress of any type	9	23%
Caregiver's burnout	5	12%
Lack of support from family	3	7%
Language barrier	2	4%
Woman working	1	2%
Missing Data	16	

(Note: Statistics on 41 observations and 16 missing data.)

Findings in question 24 focuses specifically on the service provider's opinion on factors of abuse to the Hispanic elder. This question being an open-ended approach allowed the providers to present the factors as they perceived it or have experienced while working in the field. Out of the total of 57 participants, nine different factors were tabulated. The distribution of the responses were as follows: twelve workers (N-12 or 30%) stated financial stress as the factor of abuse, six workers (N-6 or 15%) stated stress of the caregiver, four workers (N-4 or 10%)

stated alcohol and drug abuse. Another four workers, (N-4 or 10%) stated, "woman's sandwich generation role" as the main factor causing abuse. There were also four factors identified by three workers (N-3 or 8%). The factors were: Lack of communication, ignorance of the elder's needs, children overwhelmed with own problems, and change in cultural values. There were also one statement of role reversal and one statement of resentment for the responsibility of caring for the elder. It is important to note that stress is stated by 45% of the respondents as a precipitating factor of abuse. Followed by the factors, go alcohol and drugs. Table 15 illustrates these findings.

Table 15
Distribution of the Number of Subjects by Provider's Opinion as to Identified Factors of Abuse to the Hispanic Elder

Providers Opinion	No. of Subjects	Percentage
Financial stress	12	30%
Caregiver's stress	6	15%
Alcohol and Drug abuse	4	10%
Woman's sandwich generation role	4	10%
Lack of communication	3	8%
Ignorance of the elder's needs	3	8%
Children overwhelmed with own problems	3	8%
Change in cultural values	3	8%
Parenting role reversal	1	3%
Resentment for the responsibility	1	3%
Missing Data	17	

(Note: Statistics on 40 observations and 17 missing data.)

CHAPTER V

RECOMMENDATIONS AND CONCLUSIONS

Elder abuse is a difficult situation for the abuser and for the abused elder. As discussed in the Review of Literature, most of the abuse to the elder is done by a family member. Stress of the caregiver plays a major role, frequently an ill-prepared spouse, lacking important nursing skills or knowledge of the available community resources. Physical elder abuse is often associated with the use of alcohol and/or drugs, either by the caregiver or another family member.

CONCLUSIONS.

This researcher supported what existing literature has presented on elder abuse in general; that abuse is committed by a family member. Stress in the caretaker is considered to be a major factor of abuse, and alcohol and drugs play a big role in physical abuse. On these three issues, the service providers' answers were consistent. However, when asked directly about their perception in relation to abuse among the Hispanic elder population, the responses were inconsistent, and often the questions were not answered. Consequently, in regard to elder abuse within the Hispanic population, this researcher can neither support nor refute the research literature due to the small sample that actually answered the

question and the high percentage that answered unknown.

The major findings of this research within the Hispanic group is the perception of the service providers of violence to be limited to the Mexicans, Chicanos and Mexican Americans. It was found from 30 respondents that 24 perceived the Mexicans as violent, only 6 participants perceived other Hispanics as violent. However, when this question was given in general terms as "Yes". "No" and "Unknown", 31 participants answered "Unknown", which brings a correlation with the 27 participants who did not answer the question when given the specific population of a Hispanic group.

RECOMMENDATIONS TO PREVENT ABUSE.

It is recommended that all service providers and seniors' advocates attend training sessions and conferences to increase their awareness and key indicators of adult abuse. Service providers working directly with the Hispanic elder such as doctors, nurses, social workers, etc., who are required by law to report physical abuse, should be more aware of the values and traditions of the Hispanic population. This may facilitate their helping the Hispanic elder to accept services.

The community in general must be educated to report abuse to Adult Protective Service, Police Department and the Long Term Care Ombudsman Coordinator for the nursing

or residential care institutionalized elder .

Caregivers should be encouraged to seek respite programs. In some cases, family therapy. This is essential in order to maintain healthy communication, and consequently, a healthy marital relationship.

The elder must be educated on alternatives when being abused. The senior center should provide guest speakers from The Adult Protective Services Program, Senior Adult Legal Assistance and The Elder Abuse Task Force.

RECOMMENDATIONS FOR FUTURE RESEARCH.

It is recommended that a quantitative data be sought to measure the attitudes and perceptions of the service providers on elder abuse within the Hispanic population. It is imperative that new research instrument be used with clearer questions to prevent missing data. To avoid the limitations of this study, a large random sample must be utilized.

It is recommended that research be pursued, not with the service providers but with the abused and their families, specifically, to see how the action of abuse affects other family members.

FOOTNOTES

1. Select Committee on Aging, "Effects in Crime of the Elderly", p. 5.

2. Asociacion Nacional Pro-Personas Mayores, Facts Sheet/Suforma 1980, p. 2.

3. Select Committee on Aging, "Effects in Crime of the Elderly", 1980, p. 6.

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6. Beck, C.M. and Phillips, L.K. "Abuse of the Elderly", p. 99.

7. Valle, R. and Mendoza, L. The Elder Latino, San Diego, CA: 1983. p. 7.

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10. Butler, R. and Lewis, M. Aging and Mental Health Positive Psychosocial Approach. p. 37.

11. Fact Sheet (Asociacion Nacional Pro-Personas Mayores, Los Angeles, 1980). p. 3.

12. Ibid. p. 4.

13. Ibid. p. 1.

14. Lebowitz, B. Elderly Abuse, Paper Presented at the American Society on Aging Annual Meeting, San Francisco, CA 1985.

15. Ibid.

16. Giordano, N. and Giordano, J. Elder Abuse. p. 233.

17. Quinn, M. and Tomita, S. K. Elder Abuse and Neglect. p. 5.

18. Mickish, J. Elder Abuse, 1985. p. 118

19. Quinn, M. and Tomika, S.K. p. 23.

20. Valle, R. and Mendoza, S. 1983. p.

21. Lebowitz, B. A.S.A. Conference, San Francisco, CA 1985.

22. Valle, R. and Mendoza, L. 1983. p. 25.

23. Phillips, L.R. Geriatric Nursing, 1987 p. 239.

24. Krasnow, M. and Fleshner, E. Parental Abuse, 1979. p. 13.

25. Quinn, M. and Tonita, S.K. 1986. p. 9.

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30. Mickish, J.E. Elder Abuse, 1985. p. 45.

31. Fowler, D. Aging, 1983. p. 339.

32. American Society on Aging Handout. Conference 1985

33. Ibid.

34. Ibid.

35. Ibid.

36. Ibid.

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CONSENT FORM (To be read by the prospective respondent)

Information for this study will be collected by personal interview and this study is done as partial fulfillment of requirements for the Master of Social Work (MSW) at San Jose State University.

The goal of this study is to obtain an understanding of service providers' attitudes and perceptions of Hispanic elderly abuse, its related causes and the degree of family involvement in perpetrating elderly abuse.

The respondent will record the responses and no expected risk or discomfort with the questionnaire.

Participants' identity is kept strictly confidential and will be used only for the purposes of this study.

Participation is voluntary and you may discontinue the questionnaire at any time. On the average, the questionnaire will take approximately fifteen minutes to complete. Any questions you may have concerning this study will be answered by the researcher.

Her telephone number and the number of her faculty adviser, Dr. Dieppa, appear below.

Thank you for your cooperation. Your signature below signifies that you volunteered for this study.

Signature Date

Julie Luque Serrano
(408) 978-9599

Dr. Ismael Dieppa
(408) 277-2235

QUESTIONNAIRE

1. Circle your highest level of education.

   Grades 3-4-5-6-7-8-0-10-11-12

   College 1-2-3-4

   Grad School 5-6-7-8

2. Occupation _____

   Degree _____

   Area of Concentration _____

3. Do you work with Hispanic Elderly? __Yes __ No

4. Do you speak Spanish? _____Yes _____ No

5. If yes, do you speak Spanish?

   ___Fluently ___With some difficulties

   ___Very little ___Bicultural

6. How long have you worked with Hispanic Elderly?

   ___Years ___Months

7. What services does your agency provide?

   ___Mental Health ___Health

   ___Nutrition ___Protective Services

   ___Legal ___Case Management

   ___Ombudsman ___Other (specify)

8. In your opinion, is it common for the abuse of the elderly to occur within the Hispanic community:

   ___Yes ___No ___ Unknown

9. If it does, does it occur equally among all Hispanics?

___Yes ___No ___Unknown

10. Is there a socio-economic group within the Hispanic community in which its occurrence is more frequently noted?

___Yes ___No ___Unknown

11. If yes, in what group is the abuse more frequently noted?

___Low Income Class ___Middle Income Class

12. In what Hispanic groups have you seen elderly abuse?

___Mexican-American ___Chicanos, Mexicans

___Puerto Rican ___South/Central Americans

___Cuban ___Others

13. Is there the existence of violence among the Hispanic family:

___Yes ___No ___Unknown

14. If yes, in what group is it more frequently noted?

___Mexican-American ___Chicanos, Mexicans

___Puerto Ricans ___South/Central Americans

___Cubans ___Others

15. If violence does occur, what is the degree in which abuse occurs?

___Most of the time ___Some of the time

___Rarely ___Not sure

16. If abuse does occur in a violent situation, is violence an accepted norm within that particular family?

___Yes ___No ___Unknown

17. If, and when, abuse does occur, by whom is it initiated?

___Son ___Daughter

___Spouse ___Relative (familial)

___Caregiver ___Other

18. If and when the abuse occurs, is there the existence of alcohol abuse?

___Yes ___No ___Sometimes

19. If and when the abuse occurs, is there the existence of drugs abuse (e.g., cocaine, marijuana, etc.)?

___Yes ___No ___Sometimes

20. If and when abuse is found to have occurred, what type is most common:

___Physical ___Financial ___Psychological

___Neglect Other (specify): _____

21. If there is the existence of parent abuse, is the abused inclined to report the abuse?

___All of the time ___ Some of the time

___Rarely ___Never

22. If there is the existence of elderly abuse, who are more apt to be abused?

___Single man ___Single woman

___Widows ___Widowers

___Man and Woman Other (specify) _____

23. In your opinion, what are the most frequent precipitating factors of abuse? _____

_____

24. In your opinion, what are the factors that are involved in elderly abuse among the Hispanic community? (specify) _____

_____

_____

25. As a service provider, I understand the concepts: respecto (respect), orgullo (pride), dignidad (dignity).

___Yes ___No ___ I do not understand

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

CONFIDENTIAL

DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

(Chapter 1184, Statutes of 1982
Chapter 1273, Statutes of 1983
Chapter 1164, Statutes of 1985
Chapter 1120, Statutes of 1985)

NOTE: *Instructions on Reverse*

TO BE COMPLETED BY REPORTING PARTY — (Please Print or Type)

TELEPHONE INFORMATION REQUIRED *(See Shaded Areas)*

NOTE: *Submit report within 36 hours of the telephone report to your local elder protective agency or county adult protective services agency.*

FOR USE BY INVESTIGATING EPA/COUNTY APS

VICTIM NAME

SUSPECTED ABUSER NAME

REPORT NUMBER CASE NAME

DATE OF REPORT

ACTION TAKEN (✓ CHECK ONE)

☐ Victim Refuses Service ☐ Referred to APS ☐ Dismissed (Insufficient Evidence)
☐ Investigation Closed (No Further Action) ☐ Referred to Other Agency ☐ Unfounded (False Report)

A. REPORTING PARTY

NAME/TITLE OF REPORTING PARTY | SIGNATURE OF REPORTING PARTY | DATE OF THIS WRITTEN REPORT

TELEPHONE ( ) | RELATIONSHIP TO SUSPECTED VICTIM

ADDRESS STREET | CITY

B. VERBAL REPORT MADE TO

ELDER PROTECTIVE AGENCY, COUNTY APS | ADDRESS, STREET | CITY

OFFICIAL CONTACTED | TELEPHONE ( ) | DATE TIME OF TELEPHONE REPORT

LOCAL LAW ENFORCEMENT OR OTHER AGENCY CONTACTED (IF DIFFERENT FROM ABOVE) | TELEPHONE ( ) | DATE TIME OF TELEPHONE REPORT

C. VICTIM

NAME (LAST NAME FIRST) | AGE | SEX ☐ M ☐ F | RACE

ADDRESS, STREET | CITY | TELEPHONE ( )

PRESENT LOCATION (IF DIFFERENT FROM ABOVE) | CITY | TELEPHONE ( )

☐ Developmentally Disabled ☐ Mentally Disabled ☐ Physically Handicapped

D. INCIDENT INFORMATION

DATE TIME OF INCIDENT

LEARNED OF INCIDENT BY (✓ CHECK ONE)
☐ Verbal Report ☐ Observation

PLACE OF INCIDENT (✓ CHECK ONE)
☐ Board and Care ☐ Skilled Nursing Facility ☐ Private Residence ☐ Home ☐ Other (Specify) _____

TYPES OF ABUSE (✓ CHECK ALL THAT APPLY)

Perpetrated by Others

Physical:
☐ Assault, Battery ☐ Sexual ☐ Neglect ☐ Fiduciary
☐ Constraint or Deprivation ☐ Other (Specify) _____ ☐ Abandonment ☐ Mental Suffering ☐ Other (Specify) _____

Self Abuse

☐ Physical ☐ Fiduciary
☐ Suicidal ☐ Other (Specify) _____

ABUSE RESULTED IN (✓ CHECK ONE)
☐ No Medical Care ☐ Minor Medical Care ☐ Hospitalization ☐ Death ☐ Other (Specify) _____

E. RELATIONSHIP OF SUSPECTED ABUSER TO THE VICTIM

☐ Custodian ☐ Spouse ☐ Parent ☐ Offspring ☐ Other Relation (Specify) _____ ☐ No Relation ☐ Unknown

F. FAMILY MEMBER OR OTHER CONTACT PERSON FOR ABUSED

NAME | RELATIONSHIP

ADDRESS | TELEPHONE ( )

Please provide a brief narrative about any entries that you believe require explanation or clarification. Also add any additional information not requested above that you believe pertinent to the incident of physical abuse (e.g., what the victim said, known history of similar incidents). (You may attach medical notes or other information.)

General Instructions

Complete this form for each incident and each victim of suspected physical abuse of a dependent adult or elder person.

Complete shaded sections on the form when a telephone report of abuse is received.

If any item of information is unknown, write unknown beside the item.

Mandated Reporters (see below) are required to give their names.

Send one copy of this report to the agency designated for reporting collection in your county.

Reporting Instructions

Purpose

This form, as adopted by the Department of Social Services, is required under Welfare and Institutions Code, Chapter 11, Division 9, Sections 15630(a) and 15633(b), and Chapter 4.5, Division 8.5, Sections 9381(a) and 9382.

Also, this form serves to document the information given by the reporting party on the suspected incident of physical abuse of an elder (age 65 and older) and dependent adult (age 18-64).

Reporting Responsibilities

Any elder care custodian, medical practitioner, nonmedical practitioner, or employee of an elder protective agency who has actual knowledge that an elder whom he or she observes in his or her professional capacity or within the scope of his or her employment has been the victim of physical abuse shall report the suspected instance of physical abuse to an elder protective agency immediately or as soon as possible by telephone and shall prepare and send a written report thereof within 36 hours.

Any dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has actual knowledge that a dependent adult has been the victim of physical abuse, or observes a physical injury to a dependent adult under circumstances that are consistent with physical abuse, where the dependent adult's statements, or in the case of persons who have developmental disabilities, their statements or other corroborating evidence, indicate that abuse has occurred, shall report the known or suspected instance of physical abuse to the county adult protective services agency, or a local law enforcement agency immediately or as soon as possible by telephone, and shall prepare and send a written report thereof within 36 hours.

When two or more persons who are required to report are present and jointly have knowledge of a suspected instance of elder abuse or abuse of a dependent adult and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected members of the reporting teams. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

Any person knowingly failing to report, when required, an instance of elder abuse is guilty of a misdemeanor punishable by a fine not to exceed $1,000. Any person who fails to report, when required, an instance of dependent adult abuse is guilty of a misdemeanor punishable by imprisonment in the county jail for a maximum of six months or fined $1,000 or both imprisonment and fine.

The identity of all persons who report under Chapter 4.5 shall be confidential and disclosed only by court order or between elder protective agencies. The identify of all persons who report under Chapter 11 shall be confidential and disclosed only between adult protective services agencies or local law enforcement agencies or their counsel, the district attorney in a criminal prosecution, or upon waiver of confidentiality by the reporter, or by court order.

Reporting Party Definitions (Mandated Reporters)

Elder Abuse (Any elder care custodian, medical practitioner, nonmedical practitioner or employee of an elder protective agency.)

"Elder care custodian" means an administrator of a community care facility licensed to care for the elderly, a public assistance worker, a probation officer, a social worker, a licensed home aide, or an employee of an elder care institution, including personnel of residential care facilities, skilled nursing facilities, and intermediate care facilities.

"Medical practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, osteopath, podiatrist, chiropractor, resident, intern, nurse, pharmacist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

"Nonmedical practitioner" means a state or county public health employee who treats an elder for any condition, a paramedic, a coroner, a geriatric or family counselor, or a lawyer.

Dependent Adult Abuse (Any dependent adult care custodian, health practitioner or employee of a county adult protective services agency or a local law enforcement agency.)

"Care custodian" is defined as an administrator or an employee of any of the following public or private facilities:

- Health facility
- Clinic
- Home health agency
- Educational institution
- Sheltered workshop
- Camp
- Respite care facility
- Residential care institution, including foster homes and group homes
- Community care facility
- Adult day care facility, including adult day health care facilities
- Regional center for persons with developmental disabilities
- Licensing worker or evaluator
- Public assistance worker
- Adult protective services agency
- Patient's rights advocate
- Nursing home ombudsman
- Legal guardian or conservator
- Skilled nursing facility
- Intermediate care facility
- Local law enforcement agency
- Any other person who provides goods or services necessary to avoid physical harm or mental suffering and who perform duties.

(WIC Section 15610(g), AB 238, WIC Section 15610(h), AB 1603)

"Health Practitioner means:

- Physician and surgeon
- Psychologist
- Resident intern
- Chiropractor
- Dental hygienist
- Psychiatrist
- Dentist
- Podiatrist
- Licensed nurse
- Paramedic

A marriage, family and child counselor trainee or unlicensed intern as defined in subdivision (c) of Section 4980.03 and Section 4980.44 respectively of the Business and Professions Code.

Marriage, family, and child counselor or any other person licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

Any emergency medical technician I or II.

A person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

State or county public health or social service employee who treats a dependent adult for any condition.

Coroner

Religious practitioner who diagnoses, examines or treats dependent adults.

(WIC Section 15610(h), AB 238 and AB 1603)

*"Adult protective services agency" means a county welfare or social services department. (WIC Section 15610 i and j, AB 238 and AB 1603, respectively.)

MANDATORY REPORTING OF ELDER ABUSE

Senate Bill 1210, introduced by Senator Carpenter (Chapter 1273, Amending Welfare and Institutional Code) states that:

The following individuals who have actual knowledge that an elder who they observe in their professional capacity or within the scope of their employment has been the victim of physical abuse must report that abuse.

Elder Care Custodians, including administrators of community care facilities, public assistance workers, probation officers, social workers, licensed home aids, employees of residential care facilities, skilled nursing homes and intermediate facilities.

Medical Practitioners, including physicians, psychiatrists, dentists, nurses, podiatrists, and chiropractors.

Non-medical practitioners, including paramedics, counselors, and lawyers.

Physical Abuse includes direct beatings, sexual assault, unreasonable physical restraint or prolonged deprivation of food or water by individuals who care for the individual or stand in a position of trust with them.

Penalty: Failure of the above individuals to report is a misdemeanor punishable by a fine not to exceed $1,000.

The bill further states that:

Anybody may report elder abuse.

This includes physical abuse (defined above) as well as the following types of abuse and neglect.

Fiduciary Abuse, where any person who stands in a position of trust to an elder, willfully steals the money or property of that elder, or secretes or appropriates the money or property of that elder, to any use or purpose not in the due and lawful execution of his or her trust.

Neglect, including failure to assist in personal hygiene or in the provision of food and clothing for an elder; failure to provide medical care for the physical and mental health needs of the elder (this doesn't include instances in which an elder refuses treatment); failure to protect an elder from health and safety hazards; failure to prevent malnutrition.

Abandonment, which means the desertion of willful forsaking of an elder person by any person having the care or custody of that elder under circumstances in which a reasonable person would continue to provide care or custody.

What kind of reports are required?

Telephone reports should be made as soon as possible after the incident of abuse to the San Mateo County Health Services, Long Term Care Division (573-3900). When calling LTC, individuals should specify if they are reporting cases. Reports should include:

- the name of the person making the report. (This is not required if the person is voluntarily reporting);
- the name, address and age of the elder;
- the nature and extent of the elders condition;
- other information which led the person to suspect elder abuse.

Written reports shall be prepared and sent within 36 hours of the incident. Forms will be provided for written reports by the State Department of Social Services and/or Long Term Care Division.

Please send us the same reporting form both for mandatory reporting of suspected physical abuse and if you wish to report voluntarily other types of abuse.

Other things you should know about SB 1210:

- No person required to report elder abuse will bear criminal liability for reporting suspected elder abuse.
- No other person will bear liability for reporting suspected abuse unless the person knows the report is false.
- When two or more people who are required to report know about a case, they may reach an agreement to have one of them make the report.
- The duty to report is individual. No supervisor or administrator may impede or prohibit reporting.
- The identities of those filing reports will be kept confidential if so requested.
- A victim of abuse may refuse or withdraw consent to any investigation or provision of services which are initiated as a result of the report.
- In court proceedings or administrative hearings, neither the physician-patient privilege nor the phychotherapist-patient privilege apply to specific elder abuse information required to be reported.

For consultation on elder abuse cases, contact the Long Term Care Division at 573-3900.