

**Prevention through Registration: An Analysis of the creation, implementation, and
maintenance of an Elder Abuse Registry**

By

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By

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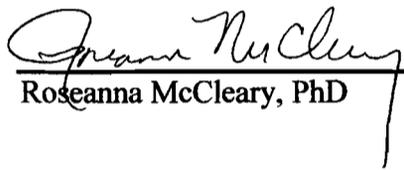
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This project has been accepted on behalf of the Department of Social Work by her faculty
supervisor.


Roseanna McCleary, PhD

Dedication

I dedicate this project with deep gratitude and appreciation to Shirley Krohn, Rose McCleary, My Parents, and My Grandparents. To Shirley and Rose for their tireless empowerment, determination, encouragement, unwavering faith in me, and continued patience through the entire process. To My Parents and My Grandparents for sharing their confidence and optimism when mine was lost in a minefield of uncertainty and stress. For without all of their input and guidance none of these pages would have been written and this research never started.

Additionally, I sincerely want to thank each and every stakeholder who shared their opinions, playing an essential part in making this project a success.

Abstract

Through stakeholder interviews and in-depth literature review this project explored the feasibility of creating, implementing, and maintaining a California elder abuse registry. This project aimed to formulate a white paper for the California Senior Legislature for future proposal development. Five stakeholders from across California were interviewed. Utilizing content analysis and grounded theory analysis, interview data were examined leading to the development of a model. The resulting model was a visualization of stakeholders' knowledge and perceptions about elder abuse registry issues. The model contains three phases, integrated categories, and subcategories. The model was grounded in that data and supported by literature. The findings and resulting model support the feasibility of California creating, implementing, and maintaining an elder abuse registry. The Researcher concluded with three recommendations for future research and California elder abuse registry creation.

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Prevention through Registration:

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Chapter One: Introduction

During the years 1946 to 1964, America experienced a significant increase in the birth rate termed the Baby Boom. In 2011 the first wave of those baby boomers started turning 65. An estimated “10,000 people will turn 65 every day—and continue to do so for the next 20 years” (Alliance on Aging, 2010, p. 1). Never in the history of the United States has such a phenomenon been observed. Organizations and institutions around the United States pithily call this senior boom the “Graying of America.” The United States Census Bureau (2008) estimates that in 2006 people aged 65 and older represented nearly 10 percent of the total California population totaling 4 million persons. These numbers are expected to double by the year 2030 (U.S. Census Bureau, Population Division, 2008).

As the numbers of individuals aged 65 and older rises, so does the rate of individuals in need of some form of care. The United States has seen a steady increase over the last several years in the number of persons 65 and older in need of help with everyday tasks (National Alliance for Care-giving & AARP, 2004). Additionally, rates of this same age group suffering from chronic illnesses, debilitating disorders, and cognitive impairments increased considerably. The National Alliance for Care-giving and AARP (2004) report that 34 million individuals are caregivers for someone aged 55 and over; 5 to 8 million of that number care for individuals over 65 who need help with daily activities. The rate of increase in individuals needing informal and formal care will increase exponentially over the next few decades. The as the number of vulnerable adults 65 and older rises, so does the increase in risk of this group in the overall population to elder abuse (Subcommittee on Human Services, 1989).

Parallel these two groups, vulnerable aging individuals over 65 and caregivers, the people who take care of them, will increase together. As these two interdependent groups become more entangled, new issues, needs, and tensions will develop. What consequences will present themselves? The NCEA (1996) found that for a single year at least 500,000 aging individuals in home care settings were abused, neglected, exploited, and/or experienced self-neglect. Between 1 to 2 million individuals 65 and older have been victimized by someone they relied on for protection or care. The majority of abusive situations happen in a care-giving environment (Teaster, 2002). Therefore, the main stage for the occurrence of elder abuse is the home. For a vulnerable adult, this means either a private home or a long-term care setting.

The National Elder Abuse Incidence Study (1998) found that 95 % of abuse perpetrators are informal caregivers, meaning they come into contact with the individual through the private home (family, friend, or private paid caregiver)(NCEA, 1998b). Huber, Borders, Netting and Nelson (2001) assert “no national statistics exist on abuse in long-term care” (p. 62). Similarly, Jogerst, Daly, and Hartz (2005) examining the sources, numbers, and incidence of elder abuse reports find that there is no complete data on the range or extent of elder abuse in long-term care settings. They suggest this is due to the unsystematic way that data are collected from a variety of sources and not systematically collected together anywhere. Abuse in both settings happens at an alarming and unfortunately, extremely underreported rates.

Heller (2000) asserts that “no one knows for certain how many elderly people become victims of elder abuse each year...it ranks among the most underreported crimes in the country” (p.1). Researchers assert that the elder abuse phenomenon is like an iceberg (Heller, 2000); reported cases are the tip above the water, whereas the main portion that which goes unreported looms menacingly unmeasured below the surface. One study suggests that if one excludes self-

neglect from the reports only 1 in every 14 elder abuse incidents is reported to public authorities (Pillemer & Fainkelhor, 1988).

What do we as a nation receive if you mix increased numbers of vulnerable adults over 65, caregivers with authority/control, and increasing number of domestic settings where both these groups are in constant contact? Elder abuse experts such as Rebecca Mitchell (Chicago elder law attorney) and Paul Greenwood (San Diego deputy District Attorney) “predict that incidents of elder abuse and neglect will only increase as the ranks of senior citizens continue to swell” (Heller, 2000, p. 2). Past statistics support Mitchell and Greenwood’s prediction: in one decade from 1986 to 1996 reports of elder abuse rose by 150% while the population of individuals 65 and older rose by only 10% (Heller, 2000). Just imagine what will happen when the population of those 65 and older doubles by 2030. And if one stretches the imagination just a bit further, is this just the tip of the iceberg? Will the coming era of the “Graying of America” be known to the coming generations as the “Senior Abuse Boom” or the time forgotten generation?

Project Purpose

This project will explore the feasibility of establishing a California elder abuse registry. First, this project will, through an in-depth review of literature, provide a foundation for the creation of elder abuse registries, their implementation, use, and maintenance. Second, this project integrates the literature review with stakeholder interviews that identified major issues, elements, knowledge known, preferences, and educated opinions on elder abuse registries. These interviews will provide in depth information about how elder abuse practitioners conceptualize an elder abuse registry and an overall picture of what practitioners believe are the ultimate benefits and drawbacks. The purpose of this project is to integrate the current knowledge of elder abuse registries with an analysis of stakeholder views into a format that will inform future policy

and legislation. This integration will take the format of a White Paper that will facilitate the educating and informing of legislators regarding issues surrounding the creation, implementation, and maintenance of an online Elder Abuse registry.

This project will inform the legislative process in relation to elder abuse that includes input from practitioners in the elder abuse arena. It will advocate for the protection and rights of elderly/older individuals, and work towards empowering older adults, their families and guardians in taking elder abuse prevention into their own hands. It will inform policymakers of the prevention needs of older adults and the feasibility of enacting uniform data reporting registry as future legislation. This presents important research questions for exploration:

1. Is it feasible to create an elder abuse registry in California?
2. What resources are needed and/or available?
3. What barriers exist?

The first portion of this project will consist of a comprehensive literature review on related issues of elder abuse, theory, registry development, and elder abuse registries. This first section will provide the foundation for the interview questions and information collected. The second portion will consist of the stakeholder interviews: data collection and data analysis. This section will provide the needed information for primary recommendations and actions.

Chapter Two: Literature Review

The following is a review of existing literature focused on available information related to the creation, implementation, and maintenance of an elder abuse registry. Little empirical information was available, specifically focused on elder abuse registries. Related issues were explored including: elder abuse research, victimization theory, the development registry use in United States, elder abuse registry information, international registry use, a case study of the recent information available on Delaware's online elder abuse registry, and elder abuse registry related legislation.

Elder Abuse Research

History of recognition of elder abuse.

Elder abuse is not a new concept. Costa (1993) asserts it is mentioned by the prophet Sirach as early as 200 B.C. The author de Beauvoir evaluates Roman attitudes and writings, suggesting they often characterize their "elders with derision and loathing"(as cited by Gorbien & Eisenstein, 2005, p. 279). Even Shakespeare in 1600 and Jonathan Swift in 1726 scrutinize early ageist attitudes and treatment of individuals. In particular Swift examined the treatment of individuals over 80 in *Gulliver's travels* (Swift, 1726). Swift's characterizations are often "quoted in gerontology classes"(Gorbien & Eisenstein, 2005, p. 279). According to authors Gorbien and Eisenstein (2005), the first modern reports of elder abuse were described in the British Medical Journal (1975) as "Granny Battering" (p. 280).

U.S. recognition of elder abuse.

The U.S. recognition of elder abuse and need started with five major governmental acts the Social Security Act of 1935-1965, congressional incentives of the 1950s, Medicare (1965), Nixon's Eight Point Directive 1971, and the Older American's Act 1978 (Gorbien & Eistein,

2005; OSLTCO, 2010). The Social Security Act and creation of Medicare attempted to address poverty and medical care in the elderly. Additionally, during the 1950's, U.S. Congress attempted to motivate states to develop adult protective services to provide care for abused elderly with financial incentives (Gorbien & Eisenstein, 2005). It was during the 1970's that abuse and neglect in convalescent and nursing homes were brought to the forefront (Grobien & Eisenstein, 2005). With Nixon's Eight Point Directive 1971 and the Older American's Act of 1978 brought about in-depth elder abuse studies and the creation of the long-term care Ombudsmen program with-in many states (including California in 1975) (OSLTCO, 2010).

This movement toward recognizing elder abuse as a social problem culminated in the United States House of Representatives Select Committee on Aging (1981). This Select Committee on Aging was the first to allow elder abuse victims to personally testify on their own behalf. The findings of the Committee were

“elder abuse is far from an isolated and localized problem involving a few frail elderly and their pathological offspring. The problem is a full-scale national problem which exists with a frequency which few have dared to imagine. In fact, abuse of the elderly by their loved ones and caretakers exists with a frequency and rate only slightly less than child abuse on the basis of the data supplied by the States”(as cited by Gorbien & Eisenstein, 2005).

It was the findings of this committee that lead to the passage of the Elder Abuse Prevention, Identification, and Treatment Act of 1985 (Gorbien & Eisenstein, 2005). These actions and trends within the system started the modern movement and recognition of elder abuse within the United States.

Definition of elder abuse.

Thirty years later after the first recognition of elder abuse within the U.S., there is still no standardized and comprehensively used definition among all agencies, organizations, and programs. Definitions vary widely among law enforcement, legislators, social service agencies, and community organizations. Why? Law enforcement agencies use legal definitions including the California Penal Code Section 386 with elements of how to prosecute and criminalize (as cited by Mierson, 2009). Legislators rely on definitions developed by P.C. 386 or laws such as the Elder Abuse Prevention, Identification and Treatment Act of 1985: “willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish, or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish or mental illness” (as cited by Gorbien & Eisenstein, 2005). Social service agencies use definitions based on the transactions between caregiver and elder, needs, inability to meet needs, and bad fit to environment (Gorbien & Eisenstein, 2005). A myriad of community-based organizations may use a variety or form of the definition.

The first major effort to standardize a definition was made during “a consensus conference of the National Center on Elder Abuse (NCEA) and the National Elder Abuse Incidence Study (NEAIS)” (Gorbien & Eisenstein, 2005, p. 283). The conference instituted definitions for seven types of elder abuse: physical, sexual, emotional/psychological, financial/material, abandonment, neglect and self-neglect (Gorbien & Eisenstein, 2005; Tatara, 1990). The use of variable definitions creates difficulties for researchers compiling distinct national statistics on incidence and prevalence of elder abuse across the U. S. It is hard to stipulate commission and omission of what acts are elder abuse. Some states still do not report

financial abuse with other types of elder abuse, and many states do not record accurate statistics on any type of abuse.

Prevalence.

All researchers approach studying the prevalence of elder abuse with one inherent limitation that current and past methodology, conceptual difficulties, and underreporting lead to distinct/expected underestimations. Pillmer and Finkelhor (1988) completed one of the first comprehensive and landmark studies. They suggest a prevalence rate of 32 per 1,000 individuals 65 and older. Of these cases of abuse: physical abuse, verbal abuse, and neglect, were found to be the most reported types (Pillmer & Finkelhor, 1988). Further, they discovered that 13 out of 14 situations of elder abuse go unreported (Pillmer & Finkelhor, 1988). Radically different than the rather moderate findings by U.S. researchers, Comijs et al. (1998) studied a group of 69 to 89 year olds living in a Netherlands community. Researchers studied physical abuse, verbal abuse, financial abuse, and neglect. Within this community, they found an overall prevalence rate of 56%. Gorbein and Eisenstein (2005) assert that Britain and Canada report rates comparable to the Netherlands study. In 2003, the Research Council Panel found in a national prevalence study that anywhere between one to two million individuals aged 65 and older have been victimized by a caregiver. Lachs and Pillemer (2004) approximate the frequency of elder abuse from 2% to 10% of the total number of individuals 65 and older based on various methodologies and definitions.

Incidence.

Similar limitations affect incidence rates studies as those affecting prevalence studies. Block and Sinnott (1979) estimate the incidence rate for an average year in Maryland at 4%. The NCEA (1998b) conducted the National Elder Abuse Incidence Study finding that 450,000

individuals 60 and older were abused in a one year period. When the results were adjusted to add self-neglect, 551,000 individuals were affected. They calculated rates of elder abuse reports for 17 of the 50 states at 190,005, 242,430 elder abuse investigations in 47 states, and 102,879 cases of substantiated elder abuse. Jogerst et al. (2003) found the highest rate of reporting in states with mandatory reporting laws like California. In 2000, all of the states were asked to respond to the Survey of State Adult Protective Services. The survey asked for states to give the number of elder abuse reports for the current year of service provision. All states provided data totaling 472,000 reports (NCEA, 2003). The Administration on Aging (2003) reported that for 2003 the National Long-Term Care Ombudsmen recorded 21,000 reports of abuse (NCEA, 1998).

New York state elder abuse prevalence study (nyseap).

The NYSEAP (2010) is the first prevalence study of its kind to take place at the state level within the United States (Hoytt, 2011). The NYSEAP (2010) should be considered one of the most complete statewide studies of elder abuse (Hoytt, 2011). The NYSEAP (2010) interviewed 4,100 elders, and received reports from 292 agencies. The study combined methodologies of “self-reported prevalence survey” and “documented case study” (Hoytt, 2011, p.2). The Survey collected portions of data from 62 counties (Hoytt, 2011). The data collection and synthesis took place over the course of one year (Hoytt, 2011). The final report was released in 2011(Hoytt, 2011).

The NYSEAP had four significant findings. First, they discovered “a dramatic gap between the rate of elder abuse events reported by older New Yorkers and the number of cases referred to and served in the formal elder abuse service system” (Hoytt, 2011, p.2). Secondly, findings produced “an elder abuse incidence rate in New York State that was nearly 24 times

greater than the number of cases referred to social services, law enforcement, or legal authorities” (Hoytt, 2011, p.2). Third, the NYSEAP found

psychological abuse was the most common form of mistreatment reported by agencies providing data on elder abuse victims in the documented case study.

This finding stands in contrast to the results of the self-reported study in which financial exploitation was the most prevalent form of mistreatment reported by respondents as having taken place in the year preceding the survey (Hoytt, 2011, p.2).

Lastly, they estimate “the incidence rate...to the general population of older New Yorkers...[as] 260,000 older adults in the state had been victims of at least one form of elder abuse in the preceding year (a span of 12 months between 2008-2009)” (Hoytt, 2010, p.2). These findings suggest that a study such as the NYSEAP may provide results that can be generalized.

Elder abusers.

Little research is been conducted on elder abusers and what causes individuals to abuse. The more that is understood about abusers, the better practitioners and researchers may be able to prevent and assess risk of abuse. NEAIS (1998) found that caregivers commit 95% of elder abuse. Research shows that adult children and grandchildren (50%) are the most common abusers with spouses being a close second (20% to 40%) (Pillemer & Sutor, 1992). Of the two sexes males tend to be the most common abusers (Tatara, 1993). Other researchers studied a cohort of caregivers over a six month period of time; 45% of caregivers reported being guilty of at least one form of abuse (Homer & Gilleard, 1990). Five typologies of abusers were developed by Ramsey-Klawnsnik (2000): the overwhelmed, the impaired, the narcissistic, the domineering, and the sadistic. Each type of offender has distinct qualities that make them more likely to

commit specific types of abuse or different levels of severity of abuse. Information like these profiles may help researchers understand how to prevent abuse and/or identify offenders who are at the highest risk of reoffending or determine the difference between a potential abuser who will harm to an elder leading to their death vs. a caregiver in need of support.

Adkisson, Hill, Korber, and Vogel (2010) identified 20 cases from searches of the California Department of Public Health and California Department of Social Services databases. All 20 of these “nurse assistants...lost their certifications for improper conduct, but had been cleared to work in residential care facilities for the elderly” (Adkisson, Hill, Korber & Vogel, 2010, p.11). The reasons these nurse assistants had been decertified ranged from elder abuse criminal convictions to serious felony convictions and from fraud to theft (Adkisson, Hill, Korber & Vogel, 2010). Adkisson et al.,(2010) assert that part of the reason these caregivers could slip through being detected are barriers to public disclosure, vague laws, and unsystematic reporting of decertification and licensing agencies. These “dangerous caregivers” could be predatory individuals seeking more victims through other arenas of formal/informal care-giving (Adkisson, Hill, Korber & Vogel, 2010).

Theory of Victimization: Routine Activity Theory

Routine Activities Theory (RAT) suggests that crime is a common routine activity that happens all the time. Crime is a routine activity theory occurring at all levels and areas of society where/when three factors converge. These three factors are suitable target, motivated offender, and the absence of capable guardian (Cohen & Felson, 1979). RAT theorists suggest that any individual can become a motivated offender if and when a suitable target and the absence of capable guardianship come together in the same space and time. RAT theorists build on ecological theories and investigations of social structure to determine how the changing social

trends of living situations such as single person households and individual perceptions of vulnerability affect victimization (Cohen & Felson, 1979).

RAT proposes the best way to prevent the convergence of these three factors is to disrupt their coming into the same time and space together frequently (Cohen & Felson, 1979). Older adults are often very vulnerable and attractive targets due to society stereotypes/perceptions. They are perceived as weaker, less alert, gullible, lonely, and trustful. Further, they often own their homes, having a lifetime of valuable possessions, large caches of assets, and keep valuables in the home. Older adults are perceived and often do not have capable guardianship being isolated from family, friends, and community. There are motivated offenders looking for an attractive target that needs only to see him or her in absence of a guardian (Cohen & Felson, 1979). RAT suggests an understanding of why a large percentage of individuals 65 and older should qualify as part of a vulnerable population, and deserve special protection from abuse/victimization by the law, in order to prevent victimization/elder abuse.

When the three factors of motivated offender, suitable target, and absence of capable guardian combine in the life of an older individual, a situation of abuse can occur. In 2003, the National Association of States Units on Aging reported a 19.7% increase in total Adult Protective Service, APS abuse reports and an increase of 15.6% in substantiated APS cases since 2000. These real increases provide an increase in suitable/attractive elder targets, an increase in pool of motivated offenders, and the possibility of absences of any form of guardianship.

The best prevention according to RAT theorists is to stop the convergence of the three factors. The manner to minimize risk of convergence would be to change the perception of possible motivated offenders of older adults as being a suitable target, and provide them with adequate/responsible caregivers with no history of elder mistreatment, abuse perpetration, or

manipulative crimes. Many types of offender registries have been explored as a way to prevent abusers from coming into contact with vulnerable elders. Registry prevention follows the specific RAT principles of prevention and victimization.

Development of Registries in the United States

The U. S. began to contemplate the use of registries as a way to minimize risk of perpetrated abuse towards vulnerable populations. It is not known when this tendency to track abuse perpetrators began, but could possibly be based on common sense associations and the use of similar registries already in operation. Currently, registries are used through the U.S. to track abuse such as domestic violence, nursing aides, nurses, child abuse, sex offenders, and even animal abuse.

Sex offender registries.

One of the earliest forms of abuse registration was sex offender registration. California became the first state to have a sex offender registration in 1947(California Department of Justice, 2000). In 1947, registration was small scale and consisted of a record of individuals being convicted of sex offense crimes. At this time the sex offender registration program was not public or contained in a searchable database; instead it was utilized mainly by law enforcement (California Department of Justice, 2000). Later in 1996, the California Legislature passed California's Megan's Law creating the official sex offender registry (California Department of Justice, 2000). This registry contained a comprehensive list of a wide variety and volume of sex offense perpetrators (California Department of Justice, 2000). Through the efforts of Congressperson Nicole Parra, AB488 was signed into law in 2004. AB488 established the California Megan's Law website. This website provided an easily accessible way to view the sex

offender registry now currently viewable at Megan's Law Website (See <http://www.meganslaw.gov.ca>).

Several studies have found mixed results on the effectiveness of sex offender registries in stopping recidivism (Barnoski, 2005; Drake & Aos; 2009, Letourneau, Levenson, Bandyopadhyay, Sinha, & Armstrong, 2010; Welchans, 2005). Yet, Drake and Aos (2009) found that sex offender registration and notification lowered the overall rate of sex offending in the population as a whole. Surprisingly, Prescott and Rockoff (2008) found that registration and notification laws decreased the rate of new offenders, but slightly increased the rate of recidivism in previous offenders. The Department of Justice (2000) asserts that there are low rates of vigilantism associated towards offenders listed, high rates of community education, and involvement in prevention of sex offending. Evidence shows that allowing the sex offender registry to be viewed publicly through an electronic means such as a website has increased public awareness, education, self-regulation, and preventative measures (California Department of Justice, 2000). Such evidence and research shows promising areas for improvement and change for the future and provides even more related evidence for creation and study of different types of registries.

Child abuse registry.

Related to the extension of registries to track abuse and perpetrators was the development of child abuse registries. State child abuse registries started in the late 1960's (USDHHS, 2009). Currently, all states have policies and laws mandating the tracking of child abuse (USDHHS, 2008). Forty States require central registries, others require registries only by public policy; four do not require any registry (USDHHS, 2008). The U.S. Department of Health and Human Service (2009) in an Interim Report to Congress studied the elements, issues

involved in creation, implementation, maintenance, and costs associated with statewide child abuse registries. The majority of child abuse registries contain information on names of individuals convicted or with substantiated charges of child abuse (USDHHS, 2009). These registries are available for use by employers of institutions that care for children such as schools, day care, and home care (USDHHS, 2009). Problems found creating registries were due process violation of registered individuals, start up costs, and privacy rights concerns (USDHHS, 2009). Little research was conducted on the benefits associated citing abuse prevention and consumer protection (USDHHS, 2009). Overall, such research on child abuse registries lends itself well to having a similar estimation of issues than might arise with the creation of elder abuse registries.

Elder Abuse Registry Research

Adult/elder abuse registry.

In part due to the impact of child abuse and sex offender registries, policy makers, practitioners, and legislators started to contemplate similar registries for adult/elder abuse. Around the United States, both federally and statewide elder abuse registries have started controversial and heated debates. Resulting adult abuse registries are modeled largely after earlier implemented child abuse registries. Teaster et al. (2007) found that 26 states maintained elder abuse registry including: Arkansas, Delaware, Hawaii, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Mexico, Oklahoma, Oregon, Texas, Utah, Vermont, Washington, Alaska, Idaho, New Jersey, West Virginia, Wyoming, and Wisconsin. Not all of the above states maintained a specific registry of abusers, but a less formal list of individuals named in abuse cases.

The National Association of States Units on Aging (NASUA) (1997) completed the the first national evaluative research study on statewide elder abuse registries (as cited in VDSS,

2002). The NASUA (1997) explored the states that currently operated elder abuse registries, their policies and procedures (VDSS, 2002). The NASUA further identified four issues that should be addressed before the creation of an elder abuse registry: “scope of registry,” “due process,” “accessibility,” and “registry management” (VDSS, 2002, pg.11). The NASUA study provides important first assessment of the first generation of elder abuse registries.

The Virginia Department of Social Services (Duke, 1999) surveyed all 50 states as to the establishment of adult abuse registries. Thirty-three of the surveyed states returned responses: nine states did not have a registry, two states have a formal registry, and 22 states operated adult abuse registries (Duke, 1999). The VDSS survey focused on four important concepts: a concise and clear definition of an elder abuse registry, evidence from adult protective service administrators on the perception registry effectiveness, the development of a list of elder abuse registry issues including limited costs associated, and the development of a list of reasons why states did not adopt an elder abuse registry (Duke, 1999). The VDSS study offered a more recent and extensive survey of integral components and issues of elder abuse registries.

International elder abuse registry.

The United Kingdom Protection of Vulnerable Adults (POVA) Scheme was legislated in the Care Standards Act (2000) (Barnes and Bamford, 2011). The POVA Scheme was institutionalized in July 2004 (Barnes & Bamford, 2010). The UK adopted the POVA to combat elder abuse and protect vulnerable adults (Barnes & Bamford, 2011). A major part of the scheme was the introduction of a list or registry to which individuals could make referrals and check names against (Barnes & Bamford, 2011). The U. K. Care Standards Act (2000) mandates that employers report: employees, volunteers, and/related workers to the POVA that have been “reasonably...dismissed for misconduct that harmed vulnerable adults or placed them at risk of

harm” (Stevens & Manthorpe, 2007, p.284). Further, U.K. employers are mandated to check with the POVA before hiring employees to work with “vulnerable adults” (p.284). The list was to be a record of “care workers who have harmed, or who have risked harm to, a vulnerable adult” in order to ensure that they “are banned from working in a care position with vulnerable adults” (pg. 5).

In 2009, the United Kingdom’s House of Lords made a decision raising significant questions about the operation of the POVA scheme for due process type concerns. The House of Lords’ “judgement concerned Article 6 and 8 of the European Convention on Human Rights because people can be barred from working from vulnerable adults prior to any representations or appeal process” (Barnes & Bamford, 2009, pg. 8). In response to this judgment, new safeguard schemes were put into effect to protect against human right violations committed against people listed on the POVA. The POVA Scheme was then replaced by the Safeguarding Vulnerable Adults Act 2006 which utilizes the POVA list with new rules developed by the House of Lords and other policy makers (Barnes & Bamford, 2011).

Study of the POVA.

Stevens and Manthorpe (2007) concluded that the use of the United Kingdom’s POVA list can be a tool to minimize risk to vulnerable adults. Such tools can be maximized when used in conjunction with appropriate employer use and attention. Stevens & Manthorpe (2007) reviewed 100 referrals to the POVA. They found that there was an “over-representation of males and home care staff in the sample of referrals as compared with national figures” and “the tendency for male staff to be involved in more physical types of misconduct” (p. 284). Stevens and Manthorpe (2007) assert that the POVA puts the power to help minimize risk into the hands of families and employers. They suggest that many of the difficulties and issues that are part of

the POVA referral process can be mitigated if employers utilize procedure and process correctly. They conclude the preliminary evidence suggest that high risk employees with previous misconduct records against elders are being barred from employment in care giving fields. Results suggest that the POVA and related registries, despite their detractors, can help stop abuse by preventing the convergence of motivated offender, absence of a capable guardian, and vulnerable/suitable target.

The most recent U.S. elder abuse registry study.

In March 2010, the first California elder abuse registry feasibility study was released by the RAND Corporation. In response to the Tax Relief and Health Care Act (2006), Congress charge the USDHHS and the Attorney General “to assess...current elder abuse data collection systems and examin[e]...the feasibility of establishing a uniform national elder abuse database to improve the quality and accessibility of data” (RAND Corporation, 2010, p.11). The RAND Corporation study (2010) was comprised of two data collection parts: a dataset of administrative data continuously compiled from state and local agencies, and a national prevalence survey including an estimated rate of unreported elder abuse cases. RAND (2010) reviewed information, data, and procedures from adult protective service agencies, the Uniform Crime Report, the National Incident Based Reporting System, the National Crime Victimization Survey, nursing facility licensing agencies, medicaid fraud control units, long-term care ombudsmen programs, and guardianship and representative payee programs.

RAND (2010) raised several recommendations and issues including the need of a standardized definition of elder abuse, concise and clear prevalence and incidence rates, technical issues, and step-wise creation of a national elder abuse registry/database. They recommended creating a nationwide registry through a series of individual steps: 1) shifting APS

data reporting systems to a single data collection system so that all the results are available nationally into one database, 2) review efforts from model states such as Texas, Minnesota, and Georgia for ways of using internet/interdisciplinary teams to improve APS data collection, 3) promote the need of carrying out several statewide pilot projects on creating elder abuse registries, before moving to the National level, 4) utilize all of the elder abuse data sources available studied in the project.

Elder abuse registry laws and legislation.

Stiegel and Klem (2007) detailed the adult abuse registry provisions of adult protective services (APS) laws by state. They give an accurate total of states with provisions, statutes, and laws about adult abuse registries. Nineteen states and one U.S. territory have APS laws stipulating the creation of an elder abuse registry: Alaska, Arizona, Arkansas, Connecticut, Guam, Hawaii, Idaho, Iowa, Kansas, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, Oklahoma, Texas, Utah, Vermont, and Wyoming (Stiegel & Klem, 2007). They found that many of these states have complex and mixed statutes and laws concerning how their elder abuse registries are to be managed, reported to, and handled.

Every state in the U.S has some type of prior failed/passed elder abuse registry legislation. In 2009 Delaware passed HB165 that authorized the creation of an online elder abuse registry (Longhurst, 2009). Specific to California legislature, they have two prior bills, AB2051 (Anderson, 2008) proposing the creation of a statewide online elder abuse registry and AB2171 (Cook, 2008) proposing the creation of a nationwide online elder abuse registry. They both died in session. Why? Little information is available as to the failure rate of these bills. Wolfe and Booker (Kleyman, 2010) assert that reporting on elder abuse is full of difficulties. Booker intones "I don't think there's any way to make elder abuse cases sexy to editors until they or their

relatives are victimized”(Kleyman, 2010, p.1). They both suggest that there is tension in what people want to hear and see about and what is important. This element of what people perceive is important and “sexy” gets the votes and the coverage.

Federal legislation on elder abuse registry related issues.

Federally, the Health Care Reform Bill was signed into law March 2010. Subtitle H of the Health Care Reform Legislation package contains the Elder Justice Act (American Association of Homes & Services for the Aging, 2010). Section 6703c of the Elder Justice Act recommends that a study should be conducted with stakeholders in the elder abuse profession on the feasibility and other issues related to the creation of a National Nurse Aide Registry (American Association of Homes & Services for the Aging, 2010). Such a registry would track and bar individuals who have been convicted of elder abuse crimes from being employed. This is not an elder abuse registry, but a profession specific licensing registry that addresses similar issues. The similarity between the two types of registries provides more areas of research and information to be drawn from.

Summary

Empirical research on elder abuse registries is sparse. Specifically, literature reports are descriptive, focusing on what states have registries, what is in those registries, what states have statutes for the creation, maintenance of registries, what problems have surfaced so far in relation to these registries. Most of this research was done in the late 1990’s; only one study existed that had taken place in 2010. No empirical research has been conducted concerning elder/adult abuse registries in the last decade. Only minimal research has been found that mentions the cost of creating, implementing, and maintaining registries; no research has actually been done using input from practitioners in the field of elder abuse. No one has asked practitioners: what is the

most effective way to create, use, and maintain a registry, or whether or not elder abuse registries reach the intended audiences or are utilized by institutions and individuals. Minimal research has been done on the possibilities surrounding putting an elder abuse online registry for public viewing.

Chapter Three: Methods

An integrative approach incorporated data from the literature review with stakeholder interviews relying in part on Glaser and Strauss' (1967) version of grounded theory research. Yegidis and Weinbach (2006) suggest that grounded theory allows researchers to learn the meanings individuals give to events, happenings, and activities they are involved in throughout their lives and develop hypotheses, not test them. Information was collected to explore stakeholder perceptions about the creation of an elder abuse registry. Specifically, the project focused on exploring what stakeholders know about elder abuse registries including the specific barriers, benefits, and elements they believe are a part of the elder abuse registry issue. The project examined stakeholder perceptions of work they were currently doing related to the stepwise creation of an elder abuse registry. After data were collected categories and themes began to emerge that started to create a better picture of the issues surrounding elder abuse registries within California.

After application to the Institutional Review Board, approval was received from the California State University, Bakersfield Institutional Review Board on December 9, 2010 to conduct stakeholder interviews (Appendix A, IRB approval).

Stakeholders

A list of elder abuse stakeholders was developed with guidance from research sponsors: Dr. Rose McCleary and California Senior Legislature member, Shirley Krohn. Stakeholders were chosen through purposive sampling by contacting individuals the sponsors knew who were associated with the elder abuse practice agencies within California. Stakeholder inclusion criteria used were individuals had to be officials, employees, researchers, prosecutors, and/or

representative of named organizations that work in the elder abuse field, English speaking, over the age of 18, and have at least two years of experienced in the elder abuse field.

The compiled list of identified stakeholders contained individuals from: the Elder Justice Work group, county district attorney offices, Area Agency on Aging, county Adult Protective Services Agencies, California Advocates for Nursing Home Reform, Center of Excellence in Elder Abuse & Neglect, and San Francisco Forensic Elder Abuse Center. Potential subjects were contacted by email with an explanation of the project and contact information for researcher and research sponsors to ask for involvement. Of the original list, 11 participants expressed willingness to be interviewed for the project.

Stakeholders who responded were sent emails including a summary of the project explaining the major purpose, a copy of the informed consent form (Appendix C: informed consent), and contact information for the researcher. The informed consent from interviewees was obtained before interviews were scheduled and completed. Each stakeholder was offered the choice to speak directly with the researcher with any questions involving the project and/or informed consent procedure. After repeated contacts of the 11 stakeholders who first expressed interest in being interviewed five stakeholders returned complete informed consent forms. All stakeholders returned their informed consent form by fax or email with electronic signature.

Data Collection

Once informed consent forms were sent back completed and reviewed interviews were scheduled at a time convenient to the stakeholder. Interviews were digitally recorded and were approximately 60 minutes, conducted solely by the researcher using an open-ended question format guide (Appendix D: interview guide). Some stakeholders requested to see the interview guide prior to the interview. It should be noted that the interview style was flexible and guided

by the particular stakeholder's particular experiences, knowledge, and feelings; therefore, the questions answered differed between interviews. Each stakeholder was asked to allow for the possibility that they might be contacted for a short follow-up interview. Follow-up interviews were not necessary.

Data Analysis

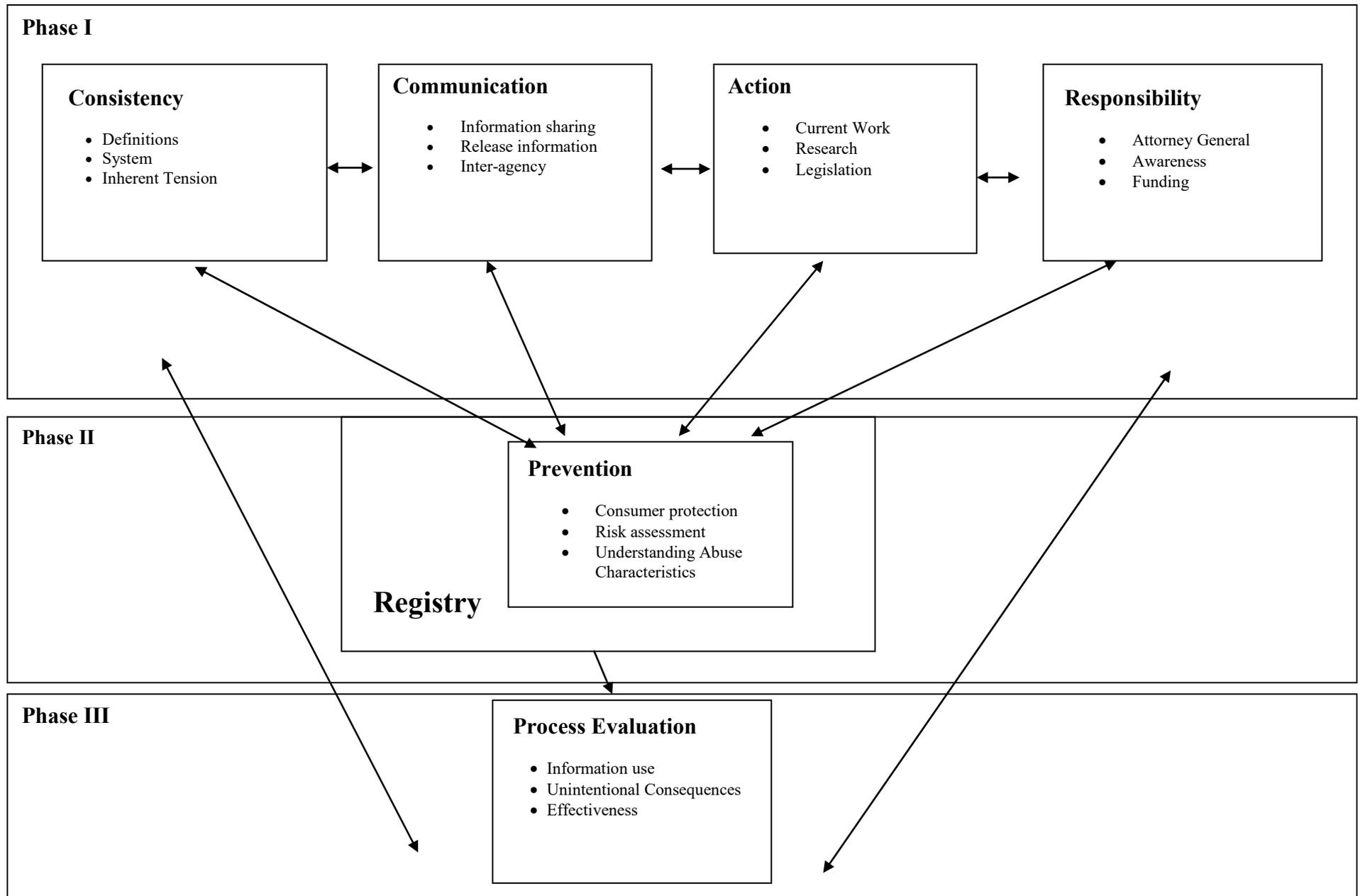
The digital recordings were transcribed. Interview data were reviewed according to live transcription/coding similar to methods perfected by Ward et al. (2004) through listening to the recorded interviews over and over as themes emerged. As data were reviewed, content analysis was employed in which a model of stakeholders' perceptions of elder abuse registries resulted.

Field notes and narratives from the digitally taped recordings were reviewed for themes and categories. Categories were developed and integrated into emergent themes, a process of basic content analysis and the constant comparative method (Glaser & Strauss, 1967; Hsieh & Shannon, 2005).

The first step of the analysis was open coding. In analyzing the content, the researcher listened repeatedly to the interview recordings making notes on words and phrases that were central to the stakeholder's testimonies. The resulting codes were developed using the actual/similar words to those used by stakeholders, as an attempt to stay grounded in the data and true to the spirit of each stakeholder. Codes were constantly compared and reviewed to prevent overlap. The second step required that the individual codes be sorted into categories. The sorting was done through in-depth and continual comparing between categories, and codes. The researcher employed the use of colored index cards and a cork bulletin board to facilitate the visual process of comparison and harrowing categories. The last step was fitting together the

categories that resulted in to a model of elder abuse registry creation and implementation (see figure 1) highlighting the themes that emerged from the analysis.

Figure I. Model for Creation, Implementation, Maintenance of an Elder Abuse Registry



The above described steps were not followed in a linear fashion, but moved in a fluid manner so that the researcher could reexamine the categories, codes, themes, and model. The resulting model was a visualization of stakeholders' knowledge and perceptions about elder abuse registry issues. The model contains three phases and integrated categories and subcategories.

Validity and Reliability

To assess the validity of the project analysis, the researcher used an inter-observer for agreement of themes and relationships identified. The use of an inter-observer provided inter-reader reliability. The outside source was abreast of the entire project, literature review, and data. The inter-observer is a published author, university professor, and competent researcher. The inter-observer analyzed the data (digital recordings, and transcripts) separate from the researcher and found agreement in codes, categories, and themes. The inter-observer found that the categories and resulting model were grounded in the data. Reliability is addressed by the researcher through the use of extensive review of related literature, grounded theory analysis, and constant comparison.

Chapter Four: Results

In this section, the model's parts will be examined as to how they fit together, as they apply to the codes and categories. The whole model will be described to provide a full picture of its meaning. The rationale behind this ordered explanation is to facilitate a systemic understanding of model; a whole only makes sense when the parts are examined and their meanings explained in relation to the overall model. Starting with the first four categories and related subcategories of the model in Phase I is the creation phase of a registry. In Phase II is the implementation phase contains the fifth category and subcategories. Finally, Phase III ends with the maintenance phase containing the sixth category and subcategories. Each phase relates to the overall model as to the time and space in which the categories and subcategories take meaning. Each category and subcategory will be described in detail with stakeholder responses and analyses.

Phase I

All of the categories in Phase I act interdependently reinforcing one another in such a way where all parts are needed to lead to and inform the creation of a registry. While the creation of a registry is inextricably linked to these categories, additional creation of a registry requires the parallel continuation of the above categories.

Consistency.

The issue of consistency was found to be a major issue for stakeholders in their responses. Stakeholders emphasized over and over again the fact that many issues involved in the elder abuse field are decentralized and variable. Overall, stakeholders highlighted the need for clearing up inconsistencies and a certain standard of consistency be applied. Stakeholders felt that these issues of consistency made the overall handling of elder abuse issues less effective and

more difficult. Stakeholders used words like “need for standardizing,” “variability,” “inconsistent,” and “ambiguous.” Stakeholders felt overall that the consistency issue affected the overall successful creation, and implementation of an elder abuse registry. There were three distinct subcategories of consistency responses from stakeholder definitions, system, and inherent tension. One hundred percent of stakeholders made a response within this category.

Definitions.

It became apparent early in the interview process that stakeholders questioned core elder abuse concepts such as “abuse,” “perpetrator,” and “registry.” Stakeholders were ambiguous over how to conceptualize an elder abuse registry. Questions were asked such as “how are you defining a registry?” or “what is a perpetrator?” One stakeholder spent a large portion of her interview discussing what she termed the “conceptual hurdles” of an elder abuse registry. The stakeholder emphasized the definitions for “abuser, abuse or elder abuse registry” were “murky.” Stakeholders generally agreed that definitions for “abuse,” and “abuser” differed depending on agency or organization. Other stakeholders referred to the term of registry as “complex,” “controversial,” and “ambiguous.” Another stakeholder summed up the issue of how to define elder abuse registry simply “there is no clear model you would get everyone to agree on at this point.”

System.

An overwhelmingly large portion of responses made by all stakeholders dealt with issues of inconsistency within the elder abuse system. These responses included agencies such as adult protective services, law enforcement, and long-term care ombudsmen. Stakeholders related that they need to be more consistent in knowledge and understanding of how the system worked and defined abuse. Stakeholders identified inconsistencies in standard of proof, data system use,

reporting abuse procedures, training, and responses to abuse as negative and in need of reform. Many stakeholders identified the issue of inconsistency in the training of APS workers/officers. Every stakeholder commented on the fact that there is no standardized training program, academy, or set of issues that must be taught to an APS worker. One stakeholder replied “an elder abuse registry would have to start out with the base, the base would have to be training of APS workers to consistently apply...the regulations in objective terms.”

Stakeholders focused on the importance of clarifying the “standard of proof” used by workers to confirm and establish abuse has taken place. A stakeholder stipulated there “is not a great deal of consistency” on how reports are confirmed. A majority of stakeholders shared that methods used for confirming abuse by APS workers differs county to county and by individual officer to officer. Another stakeholder reflected “there are counties where all reports are 100 % inclusive” based on their particular policies. Others commented that “standard of proof” required to “confirm” a report differs based on “subjectivity” and individual workers ideas and trainings. It seemed increasingly important to stakeholders that workers be trained and uphold a consistent standard of proof the same in every county. One stakeholder stated APS policy “doesn’t say it has to be beyond a reasonable doubt or a preponderance of evidence...just sort of there is something legally....about you know in your judgment or in your professional judgment.” Stakeholders differed on what they believed this standard of proof should be, one said “preponderance of evidence,” others emphasized the need to up hold a more flexible standard.

Stakeholders mentioned issues related to the inconsistency in data system used by agencies involved in the reporting of abuse, responses to abuse, and the associated knowledge of these issues. First, stakeholders stated that APS workers enter data about abuse reports that differ in their searchable fields. One stakeholder asserted “San Francisco they’ve just updated their

database so now they can search by alleged abuser...and you can run certain reports where you are able to see if a certain person has been implicated in multiple types of abuse with different potential victims.” Other stakeholders stated that APS officers have to ask supervisors or submit requests for permission to search for a suspected abuser’s name within their county database. Stakeholders on a whole felt that every county using a different system created a difficulty for tracking abuse. Additionally, stakeholders identified that they had little knowledge about the what types of systems and definitions were used by other elder abuse agencies such as the Ombudsmen or law enforcement used to report abuse. One stakeholder stated in reference to law enforcement reporting “it is true that on their reporting forms they often fail to note things like physical disability, other dependent adult aspect...age...in practice they are missed.” Collectively, stakeholders emphasized that the response of practitioners to abuse as being inconsistently applied. One stakeholder quipped “law enforcement focus on perpetrator,” “APS focuses on the victim” and “ombudsmen deal with facilities.”

Inherent tension.

Every stakeholder commented on the inconsistency between goals, mission, and program type of APS and how individual APS workers must practice. One stakeholder stated these inherent tensions of the goals and mission of APS:

so fundamental...difficult and sometimes conflicting mandate they have to respond to reports of abuse, they have to investigate these reports of abuse, and their ethical framework is not a law enforcement framework, the ethical framework is one of confidentiality, of right to self-determination, of protection...in the least restrictive environment...inherent tensions coupled with the fact that APS is a voluntary program so you don’t have any subpoena power, you don’t have any ability to pluck somebody out of

what look like an abusive situation...these tensions are really important. Sometimes you may have your I'm investigating the abuse hat on, but a lot of times what you may have is I am trying to build a relationship with that person so that I can figure out what's going on and in the meantime meals on wheels is coming

APS's mission and goals appear in conflict at all stages of their practice. The overall system runs on this same mandate of voluntariness and self-determination. Specifically, APS is asked to do two distinct jobs: be a "client centered" "social service provider" and investigate abuse. Yet, they only have the authority and power to do either if a client is willing and able to give permission. Further, some stakeholders felt that the creation and implementation of an elder abuse registry would negatively affect this weak balance of tension. One stakeholder further emphasized "what ends up happening is it in effect, it shifts the emphasis of APS...from instead of having two things going on in a corollary fashion... the clients' needs which is the point of a social work program...shifts...to the investigation." Stakeholders ardently felt that such a shift would have negative consequences. One stakeholder summarized these consequences as "the client once again is going to be the one who pays the price."

Communication.

Communication affected the ability of stakeholders to effectively handle abuse. Many responses centered on elder abuse practitioners' ability to effectively utilize communication and information about abuse, victims, and abusers. This category is defined by stakeholder responses and highlights of the importance of individual practitioners and agencies being able to communicate through written and verbal manners about cases. Additionally, stakeholders identified that only through the improvement of lines of communications within and without elder abuse agencies could a registry succeed. A majority of stakeholders gave responses that fell

within this concept. There were communication issues within APS, across APS counties, between all elder abuse agencies, and issues with how information is released and shared between agencies/public.

Stakeholders were concerned that perpetrators of elder abuse that fit into the predatory model were being missed quite often due to the fact that APS and other agencies failed to share information effectively. One stakeholder explained “people who, for example, who sign up to take care of people, (especially up north where you have little small counties right up next to each other)...scamming people in four or five counties and nobody realizes what is going on because they’re across jurisdictions.” Stakeholders acknowledge the failing of elder abuse systems to really communicate and know what is going on past their own jurisdiction. Another stakeholder stated “they don’t necessarily talk to each other.” Stakeholders on a whole supported a more comprehensive and inclusive network of communication between all levels of elder abuse practitioners. Another stakeholder asserted “within APS system that already exist...if it seems predator type[abuse crime and I] can...search within my own county to see if this alleged abuser has been linked with other victims within my own county and it would it be amazing to do that across multiple counties.” Further, stakeholders seemed to favor the idea of some type of alert system. Stakeholders felt benefits to “see if alerts of individuals that crop up as alleged abusers within counties with multiple cases and potential across counties with multiple cases.” Additional stakeholders felt you might be able to utilize “Protective Services Operations Committee or PSOC that is across counties...if you could tap them and say this person we think is potentially dangerous and start to get together a profile.”

Stakeholders emphasized the importance of being able to release information to the public and practitioners. Currently, stakeholders feel that they are kept from discussing many

important issues across jurisdictions and agency lines due to policies and laws. Stakeholders feel that APS workers and other elder abuse practitioners should receive the “permission” to discuss reports more in-depth with public individuals in order to “nuisance” the reports. One stakeholder stipulated that the “permission to disclose” some “sensitive” information is extremely important. Stakeholders felt that if an individual is named in a report that collaborating facts should also be disclosed such as “type of abuse,” “type of finding,” “how long ago the report was made,” and any other information that makes the information more digestible to receivers. One stakeholder felt these disclosures would allow information to be “weighed more carefully” and give “less opportunity for distortion.” Two Stakeholders referenced Megan’s law in relation to this issue of communication. They both related that important information has “shades of gray” that must be communicated when it is released. Each Stakeholder felt that the Megan’s law website and registry showed that communicating information to the public without sensitive disclosure and guidance would produce negative consequences.

Action.

The responses of stakeholders emphasized that certain actions and active attitudes must be accepted and carried out to pave the way for an elder abuse registry. Stakeholder’s action-oriented manner of interaction involved individual practitioner involvement, collective activities of information seeking, and policy making. Stakeholders reasoned that cultivating action was the only way that projects as complicated and large as an abuse registry could succeed. Further, stakeholders felt that action created a system where all members were engaged and attached. These engaged and attached members inform and shape policy creating a flexible and effective system able to accept a elder abuse registry. Specific to action there were three subcategories of these responses: current work, research and legislation.

Stakeholders felt the need to make known that steps are being made towards improving the overall elder abuse system. One hundred percent of stakeholders provided some responses related to current work that is taking place throughout California and the United States. Some references were made about specific acts of work in other states such as “I do know Arizona has developed some trainings on testifying and doing good documentation because they were finding, if I am not mistaken, that the documentation they were getting from social workers didn’t hold up, I believe, I believe their registry is based on confirmed APS findings.” Other references were made confirming specific counties work: “Napa County...has an automatic background check registry for caregivers” or “Sonoma County...judge who was starting some kind of registry where people with related convictions were put.” Some references dealt with the specific intervention of a stakeholder involved organization: “the Elder Justice Work Group...abuse summit...blueprint recommendations,” and “committee of ...the County Welfare Directors Association has been working on a consistency committee and they have a document that is a matrix for figuring out whether to confirm or not to confirm...and an e-learning mechanism...course.”

Stakeholders felt there was a need of further research on elder abuse registries and legislation. Once again every stakeholder used the term “research” and related issues of how they felt research and legislation should go hand in hand. Several stakeholders expressed worries over bringing a concept like an elder abuse registry to legislation without more research. One stakeholder stipulated bills that get passed that have no practical plan for application “get passed and just sit there.” Still other stakeholders emphasized the importance of “hear[ing] what other people have to say” their “reservations” and “different perspectives.” Many stakeholders felt an elder abuse registry need to be “explored.” In particular, stakeholders insisted more information

need to be gathered from other states on their use of elder abuse registries. Another stakeholder expanded “explore what’s being done in other states” and “getting stakeholders together.” Even still more general comments were made about the system in general: “APS is increasing their ability to note alleged abusers case to case...it depends upon the type of database they’re using,” and “there was a rumor one county started their own registry.”

As a form of research, several stakeholders mentioned the ideas of a “pilot project” or “task force.” These ideas of pilot project and task force are inextricably tied to the theme of research and legislation, that there must be active and interactive actions taken by stakeholders to improve the system and lead in an elder abuse registry. Some stakeholders felt the need to get “legislation for a taskforce” or “having a bill that asks for a task force, that has some funding for a task force” where legislators have a “commitment to listen” with a ‘foot in the door” to “build into this what we report back to a committee.” Other stakeholders emphasized their desire for a pilot project within a few counties in California where they utilized and implemented and then the outcomes are studied. A single stakeholder spent several minutes of her interview spelling out a strategy for a pilot program involving “start slowly...have available to professionals” for a “pilot period of time” with “public data” as a “test run with professionals” with “rules of use” then put to “the public...the amount of information the public could get would be very different than professionals.” This stakeholder even spelled out some of what she felt was important to include on the registry “address, number of times charged, reported, convictions, truncated police reports.” Further, this stakeholder stipulated “professionals receive a lot more info” and “bound by rules of use” that there should be a “transition” of “a couple of years” and it should be studied.

Responsibility.

Responsibility is defined as stakeholders' responses that deal with the need within the system of policy makers and society to recognize the true situation of elder abuse. In recognizing the situation many of the responses deal with where the accountability for changes of this nature should lie. Further, this category includes finding an area and distinct fit for an elder abuse registry. Additionally, this category deals with gathering the attention of all elder abuse field agencies and practitioners to offer up data and information to a registry. Responsibility acceptance was seen as central to the fullness and scope of a registry affecting overall success and effect. There were three subcategories of responses within this theme category: role of the attorney general, awareness, and funding. These subcategories will be discussed together as they are not distinctly separate.

Several stakeholders felt that the California Attorney General needed to take responsibility for elder abuse. One stakeholder quips "more I think about it, the more I'd like to see this land in the Attorney General's lap, mostly because they need to be more aware of how much is out there they are not getting." Stakeholders' feelings are summed up by one response:

That's very true, one of the issues there is the lack of the lack of prosecution, and when I am telling you that there is a huge difference, back now I am talking, I see it was in 2002, I was still in charge of collecting the data in...County...and we were getting, we were getting, 300 reports of abuse every month, let's say we confirmed even 10% of those and I am not even, it's probably more than that but let's say we confirmed 10%, so that is 30 per month right, so 360 for the year possibly, um the Attorney General reported that in...county in that year had 25 cases of elder abuse that year. So there is that kind of a differential between, you

know what APS, it is getting reports on what we are confirming, and what actually goes on to be prosecuted and so on in the justice system, it just a huge difference

Essentially, stakeholders felt that the society in general does not understand the amount of abuse or the abuse statistics. Some stakeholders felt that the new Attorney General might look favorably on taking elder abuse seriously, therefore, the idea and research needed to happen now. Several stakeholders emphasized the difference in response in the system to abuse reports of the elderly and children. Stakeholders seemed to see that this difference will have a negative impact on the overall impact of an elder abuse registry or the acceptance of legislation on the issue.

In part taking responsibility for elder abuse had a funding component for many stakeholders. Stakeholders seemed hesitant to put any type of legislation or programming up to the legislative chopping block at this time due to the overall economic hardship of the State and Counties. Stakeholders felt that there was currently “not enough money” within the elder abuse system to pay for or manage a project like a registry. One stakeholder mentioned “getting funding at this point in time is going to be hard.” Many stakeholders stipulated that they felt that all practitioners and researchers must be careful how they use money and make sure that new plans wouldn’t take away from already limited resources of APS and other related agencies. One stakeholder argued that funneling money into a registry would undoubtedly end up in the wrong place “money diverted to hearing processes.” Another stakeholder worried that “financing” these same administrative hearings, judges, and notification procedures that went along with a registry would “risk the limited money available to the elder abuse field going to the court system.” Stakeholders felt that a registry would trigger a hearing process not unlike costly Medical hearings. A stakeholder elaborated “are a lot of money to put on and I know when we do medical

hearings they were \$4,000 apiece, they are not cheap.” Stakeholders felt that the elder abuse system was under-funded. This issue of underfunding lead many stakeholders to be unsupportive of any programming that might divert already thin resources of APS, AAS, or LTCOP’s. Funding was such a barrier that stakeholders assert that an elder abuse registry project could not proceed unless such issues were solved.

Phase II

Phase II is the implementation phase. Stakeholders recognized that with the creation of a registry there would be several benefits and issues that would reinforced and continue the need for continuation of Phase I. The implementation phase leads specifically to a maintenance phase which is evaluative.

Prevention.

Prevention deals with the majority of benefits that the creation and implementation of a registry need. Stakeholders repeatedly stated the preventative nature of a registry. Particularly, the prevention category seemed to be tied to the overall outcome of the registry being successful if and only if, it lead to the specific prevention of elder abuse issues and overall education of the entire system. All of the stakeholders spoke of the notion and theme that a registry would lead to preventing elder abuse through protecting, updating, and educating practitioners and elders individually and collectively. One stakeholder called a registry “a great prevention tool.” There were three major areas of responses within this theme: consumer protection, risk assessment, and understanding abuse characteristics. These three areas were tied directly to what an elder abuse registry would do for elders and practitioners that would prevent victimization.

Consumer Protection & Risk Assessment.

A majority of stakeholders mentioned elements of consumer protection and risk assessment. They felt that elders and families could benefit from having an easily accessible resource to contact for extra information concerning possible private caregivers. One stakeholder felt that the profession of care giving should be “treated like the profession that it is” and information be kept in similar ways as with other professionals such as doctors, nurses, therapists, and attorneys. Stakeholders thought that such a registry would hopefully fill the gaps that various types of background checks left open. One stakeholder stated it is “difficult” for people to know “when their background checks on potential caregivers what types of crimes are included or not included on background checks...financial crimes may not be listed on any DOJ background check.” Stakeholders raised questions of whether the background checks were cost-prohibitive or accessible for many individuals seeking private caregivers. Stakeholders favored the idea of some level of information being “easily accessible” through a “registry” or “website” to give them consumer protection. Additionally, one stakeholder mentioned a registry could be used for “current investigations” or giving an employer a tool to determine “what type of a risk they[abuser] would pose in carrying out their duties” as a caregiver. Still other stakeholders emphasized further that a registry would “certainly help assess risk in any given case which is always what the goal is.” Further, stakeholders felt that such a registry would help “focus the attention” of practitioners.

Understanding Abuse Characteristics.

Further, all stakeholders felt that elder abuse needed to be understood more. That the characteristics of victims, perpetrators all need to be understood more. Stakeholders emphasized the need to track data to really understand abuse so that prevention could take place. One

stakeholder felt that abuse should be understood in order to “track behavior” through “geography, and population.” One stakeholder further felt that “the more data points” we have the better “culling of data” that agencies could carry out, allowing for more effective use of resources. Eighty percent of stakeholders realized that “very little” up to date and useful data existed about who abuses and why they abuse. Yet, stakeholders felt that this lack of knowledge was an overall weakness that an elder abuse registry could help provide an avenue to solving.

Phase III

Phase III is the Maintenance phase that stakeholders saw would increase effectiveness of the overall registry. Stakeholders spoke to this phase with the issues of evaluation and evidence based practice ideas. Stakeholders related issues to how the overall process worked in a registry and anticipated possible issues with the overall registry. Thematically, this phase contained many of the issues stakeholders recognized as overall barriers to the success of a registry currently, future, and past.

Process Evaluation.

Process evaluation was defined as all responses by stakeholders that yielded to possible issues in the maintenance and process working of a registry that would need to be checked on and handled. Stakeholders responses dealing with barriers, negatives, and possible consequences of a registry including the necessary questions of whether it accomplished specific goals. Stakeholders questioned methods of utilizing data tracked by the registry to study its overall outcomes, benefits, and costs. Stakeholders asserted that if these issues were outcomes of elder abuse registry implementation, then they must be immediately addressed and eliminated for successful continuation. Further, there was a sense through stakeholder responses that this theme would reflect back and the other categories/themes and lead to the continual working of all

categories gaining, moving forward, and backward as needed for overall success of an elder abuse registry.

Issues affecting the overall usefulness of a registry and its overall success were related to responses stakeholders had involving unintentional consequences, effectiveness, and information use. Four stakeholders used the phrase “unintended consequences” multiple times in their responses. Stakeholders were concerned about how the public and elder abuse practitioners would use information provided by the registry. They felt it was important to “be very careful with” information presented on a registry. Some felt that it could potentially cause perpetrator “civil rights” violations. Stakeholders felt that it was important that information provided do good, not harm. Stakeholders were concerned with how practitioners would let information affect their investigations. One stakeholder drove home this point by stating there is “already such a tendency for forgone conclusion and to foreclose thinking when you’re investigating.” Three stakeholders emphasized that the public doesn’t always know how to correctly understand information they are given. One stakeholder referenced this issue using Megan’s Law registry as an example stating “you know...the problem being that people don’t really analyze what they are looking at...I am thinking in terms of the Megan’s Law registry and people don’t seem to discern the difference between different levels of sexual assault.” Stakeholders felt that how this information was used by practitioners and consumers needed to be explored to determine the effect that a registry had on civil rights.

Additionally, stakeholders were concerned that a registry might decrease the reporting to APS. Stakeholders stipulated that they had heard that this had happened in “Arizona and Hawaii.” One stakeholder hypothesized that decrease in reporting was due to the fact that victims didn’t want their loved ones’ name to be put on a registry. All of these issues related to

decreasing the success and usefulness of a registry. Stakeholders were concerned with whether a registry would be effective additionally and whether the barriers to success would be handled as they “popped up.” This theme leads to the need of a evaluation of the registry that leads to updating, changing, maintaining its existence and exercising confidentiality.

Model for Creation, Implementation, and Evaluation of Elder Abuse Registry

As the above explained results show, stakeholder response yielded a model for how an elder abuse registry can be created, implemented , and maintained (see figure 1). The model contains three interrelated phases: creation, implementation, and maintenance. These phases interrelate in a cyclical fashion where even when movement leads to the next phase all previous phases continue to be important, and may be returned to for continued participation. Phase I is the creation phase where many issues and elements are developed, tried, and studied. This Phase impacts how Phase II: implementation, will activate and flow. Phase II: implementation impacts where the specifics of registry building, procedure, and utilization. While Phase II is working, Phase I may be needed to continue to address issues to successful implementation. Phase III: maintenance, evaluates how the registry impacts victim, abuser, and society including negative consequences. The outcome of Phase III leads to continuation of Phase I and Phase II to address making the registry continually effective and updated. Therefore, the model is continuous and cyclical moving back and forth between phases as is needed for the particular outcomes of each phase. Stakeholders spoke to the need of a continual and integrated model of elder abuse registry through their emphasis on interaction and flexibility in the overall nature of how elder abuse is dealt handled.

Chapter Five: Discussion

The purpose of this project was to explore the feasibility of a California elder abuse registry. This formed the scope of the research questions: Is it feasible to create an elder abuse registry in California? What resources are needed and/or available? What barriers exist? The results were a grounded theory model for registry creation, implementation, and maintenance as discussed in the Results section. This model provides support for an elder abuse registry being feasible for California. The issues of resources and barriers were answered by the comprehensive information provided through the stakeholder interviews. Information from the research questions were integrated into the grounded theory model. This model provides distinct phases and actions based on stakeholder perceptions and opinions of how to make an elder abuse registry effective and useful for public and practitioner use.

Project Connection to Current and Past Legislation and Research

As presented in the literature review, little research has been conducted in the last ten years on elder abuse registries. The major research conducted in this area was descriptive focused on surveying state registries or laws. When the results of this study are compared to the results of the NASUA (1997), Duke (1999), and RAND Corporation (2010) one becomes aware of several shared themes. Similarities include: that the barriers to registry creation were overwhelming related to due process, unintentional side effects, and inconsistency issues. All four studies showed that a new path in research needs to be taken to help end the questions about elder abuse registries. RAND Corporation (2010) recommended the creation of an elder abuse registry in small steps. Relatedly, this project provided guidance on the promising future steps to take in the process. This project supplemented research through creation of a model of a California elder abuse registry creation, implementation and maintenance. This model may be

generalizable to other states in spawning research to address the concerns of the nation in how to proceed in relation to registry creation.

California had few legislative attempts of creating elder abuse registries. Two pieces of prior legislation were found and reviewed in the literature review specific to California legislature: AB2051 (Anderson, 2008) proposing the creation of a statewide online elder abuse registry and AB2171 (Cook, 2008) proposing the creation of a nationwide online elder abuse registry. Unfortunately, both died in session and have not been reintroduced. Research shows that many elder abuse legislation does not receive the strong support or doesn't get implemented when passed. The same is true of similar pieces of legislation dealing with child abuse registries such as the Walsh Child Protection Act (1998). This is Act provided for the creation of a nationwide child abuse registry. To date, such a registry has not materialized. There is controversy over whether such a registry ever will. A history of failed legislation in California and economic crises are major barriers to establishing an elder abuse registry. Can hope loom on the horizon?

Many elder abuse research groups have recommended that related issues be studied for consideration with legislation. The California Elder Justice Workgroup (CEJW) is a group of likeminded professionals started in 2008 with funding from an Archstone Foundation grant. The group seeks "to protect the right, independence, security, and well being of vulnerable elders in California by improving the response of the legal long-term care, and protective service systems" (Nerenberg, 2011). CEJW recently released a draft report "Improving California's Response to Elder Abuse, Neglect, and Exploitation: A Blueprint 2011"(Nerenberg, 2011). This report recommends exploring the need for an abuser registry. They suggest that steps such as an abuser registry will help heal the broken system of abuse reporting and response (Nerenberg, 2011).

CEJW asserts that exploring the need for an abuser registry is an important “action step” to “ensure a comprehensive uniform response to abuser reports” (Nerenberg, 2011, pg.5). The CEJW repeatedly insists on the need to increase the ability of elder abuse practitioners to share information in an effective and useful way. Many of the recommendation in the Blueprint are similar to findings in this project.

On March 2, 2011 the U.S. Senate Special Committee on Aging held a hearing called “Justice for all: Ending Elder abuse, Neglect, and Financial Exploitation.” During this hearing movie icon Mickey Rooney testified about this personal victimization with financial exploitation, as did several other elder abuse experts. Along with these testimonies, the Government Accountability Office (GAO) Elder Justice Report was also released (Government Accountability Office, 2011). Like the Elder Abuse Victim and End Abuse in Later Life Acts, the GAO Report recommends congressional action and funding for programs and studies of nationwide studying of elder abuse. Two new pieces of legislation were introduced during this hearing the Elder Abuse Victim Act 2011 and End Abuse in Later Life Act 2011. Most importantly, the Elder Abuse Victim Act provides precedence for the recommendations made in this project.

The Elder Abuse Victim Act proposes three major innovations that lend themselves to paving the way for the next steps in research proposed by this project. First, Section 4 creates a mandate for national and statewide data collection. This Act promotes the creation of programs and studies to study perpetrators and victims in relation to elder abuse, this could lend itself to promote registry creation and implementation. Second, Section 5 creates federal grants for states to create multidisciplinary task forces to study and promote elder justice issues. This creates not only a possible avenue to get funds for the creation of a task force, but precedence for legislation

of task forces in the elder abuse field. Thirdly, the act authorizes funding of \$20 million per year for two years so that these provisions of this Act can be carried out.

This legislation, if enacted, may support statewide efforts by California to support actions and programs such as an Elder Abuse Registry. These reports and acts are bringing needed awareness and importance to elder abuse issues. This awareness may have brought elder abuse registries back to the forefront of elder abuse prevention discussions.

Project Limitations

There were three limitations of this project include: inaccessibility of some research, sampling/number of stakeholders interviewed, and need for future research.

The first limitation is that several resources needed to make a thorough literature review of the subject of elder abuse registry were inaccessible. Several of the central studies made of elder abuse registries in the United States were inaccessible and others were outdated. Unfortunately, even after continued perseverance and determination the researcher was unable to get these reports and access these resources. Further, after several attempts at contacting individuals in charge of or with experience with elder abuse registries in many states, no contacts were made. Unfortunately, contact could not be made with the director or sponsors of the Delaware legislation and online elder abuse registry. Additionally, research on elder abuse registries was limited and outdated. Much of directly related research available on elder abuse registries was outdated and tangential.

The second limitation was in the scope of the project, and number of participants. Only five stakeholders were interviewed. Although these are key stakeholders in the elder abuse field and offered a large amount experience, variety of agencies, organizations, and fields of practice, they are a very small percentage of the overall number of stakeholders within the elder abuse

field. It is also possible that their voices may not tell the whole story of practitioners within California only a small cross section. More specifically, this project attempted to reach stakeholders such as attorneys, law enforcement, and government officials. These stakeholders did not respond to the call for interviews. Unfortunately, this level of stakeholders should be accessed to provide the most comprehensive picture and multidimensional assessment of elder abuse registries.

The third limitation is that this project sought to provide research that could inform the creation of evidence based legislation. The project did accomplish providing an evidence based edge to the legislative process, but what was really found is that more research needs to take place to really accomplish the goal effectively. This research guided this investigation to the major conclusion that a much more intensive form of investigation is needed such as the formation of a task force of elder abuse practitioners on a statewide level with the cooperation of several agencies including the CEJW. Stakeholders felt that a much larger movement is needed to address the complexity and overarching themes of an elder abuse registry such as a task force/ focus group. The Researchers ran out of time.

Recommendations for Future Steps

As a product of this research, three major recommendations are offered.

Recommendation One: Collaborate with contacts made during this project to create an Elder Abuse Registry Task Force.

Action Steps:

- Assemble group of stakeholders from all levels of elder abuse practice arena including, but not limited to: adult protective services, county and state law enforcement, elder justice attorneys, long term care ombudsmen, California Senior Legislature, California

Elder Justice Workgroup, Center of Excellence in Elder Abuse & Neglect, UCI, Academy for Professional Excellence, SDSU, area agency on aging, California Advocates for Nursing Home Reform, county district attorney offices, elder abuse forensic centers, and other elder abuse and aging related organizations.

- Provide a location for task force meetings to take place on at least three times over the span of a year.
- Provide facilitators to establish an agenda, schedule for meetings, and record the meetings.
- Provide research to do an analysis of the stakeholders' ideas, plans, and recommendations.
- Establish a report of recommendations of resulting from the task force.

Recommendation Two: Develop a Strategic Plan for creating an Elder Abuse Registry.

Actions Steps:

- With the help of stakeholders and researchers rework the project model developed in this project to meet the new findings and ideas of the task force so that it can usefully inform the continued process.
- Utilize this new model as the central model for the strategic plan of creating, implementing, and maintaining an elder abuse registry.
- Provide for in the strategic report structure and path to the building relationships with counties interested in being the host for research projects.
- Disseminate the strategic plan and seek out funding and programming to make the recommendations happen.

Recommendation Three: Develop and Institute a Pilot Program with a California County utilizing the strategic plan developed by the Elder Abuser Registry Taskforce.

Actions Steps:

- Seek out funding through new legislation, grant opportunities, and private organizations to finance a pilot project built upon the model of registry creation, implementation and funding within at least one county.
- Collect data through the pilot program, providing interns, and student researchers to conduct research on the overall impact of the elder abuse registry pilot project.
- Evaluate the need for continued study and more pilot projects in other counties.
- Develop a culminating report on the overall success and outcome of the pilot project.
- Publicize this report on every social media website, local and county news channel, through newspaper and magazine articles, and in the home agencies of stakeholders, to bring about awareness, support, and interest.

Recommendation Four: Take the results of pilot project and work in collaboration with identified congress people to write evidence based and effective legislation on Elder abuse registry.

Action Steps:

- Provide all resulting resources to CSL members, interested lobbyists, and congress people in order for truly evidence based legislation to come forth.

Implications for Social Work

As the world ages, as society begins to recognize that elder abuse is a social problem, as more high profile cases such as that of Mickey Rooney come to light, more research will need to be done on elder abuse issues across the spectrum. Legislation on the elder abuse registries will

become a forefront issue. As part of social work's dedication to ethics, we are called to be a part of legislative and policy making activities. This project highlights the continued importance of social workers being involved in active research that informs and educates legislators on how to make effective, successful, and practical legislation.

Is the United States ready to handle the coming increase of the baby boomers, the senior abuse boom? No. Still to this day, not all states have mandated reporting laws, not all states have independent adult protective services, and none of the aging services programs are properly funded. The most frequent complaint amongst APS workers and long-term care programs around the U.S. is insufficient funding and staffing (Estes, Zulman, Goldberg, & Ogawa, 2001). If this is the case now...what is going to happen in a few years? Heller (2000) paints a bleak picture of the United States' ability to handle and manage "the wave of potential elderly victims in the next few decades" due to the overall lack of effective elder abuse programs and targeted lobbying efforts (p. 3).

What should we do to change the portrait that Heller (2000) paints? The National Association of States Units on Aging, NASUA (2004) recommends that new efforts be taken to engage all levels of society in becoming educated and involved in interventions against elder abuse. Further, they encourage and support collecting as much data as possible about elder abuse perpetrators stating such information is "critical for prevention, intervention and advocacy" (NASUA, 2004, pg. 3). They stipulate further that "accurate and uniform data must be continuously collected at state and national levels so that elder abuse trends can be tracked and studied" making a "concerted effort...to create uniform definitions and measures for reporting" (2004, pg. 3). One way to ensure the uniform, accurate, and continuous reporting and collection of data at the state level, is an elder abuse registry. Elder abuse registries in particular have in

the last several years become a controversial issue of debate as a way to keep elder abuses from coming into contact with vulnerable adults.

This project has implications for all areas of social work. This project calls all social workers to examine and help change policies on local, county, state, and federal levels. This project emphasizes the need for stakeholders in elder abuse to be an important part of the process of change. It calls social workers of all kinds to reach out on the macro level in the same determine, strengths based approach we do on the individual, family, and group levels.

Finally, the NASW Code of Ethics asserts that social workers are mandated to be interested, advocating for, and working towards social justice (NASW, 2008). More and more as the so-called Silver Tsunami approaches it becomes the responsibility of social workers to seek social justice for our older population. We have a duty to examine how elder abuse registries would impact not only victims, the older population, but also perpetrators and the society as a whole. We must seek social justice, through researching elder abuse registries to make sure the needs of protection and prevention against abuse does not go unheard in order to push through or break down legislation on the issue. Not only are older adults needs heard, but active and effective actions are being taken to provide the best protections, programs, and innovations available.

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Appendix A

IRB Approval



**Grants, Research, and Sponsored Programs
California State University, Bakersfield**

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Institutional Review Board for Human Subjects Research

Date: 09 December 2010
To: Courtney Morris, MSW Student
cc: Paul Newberry, IRB Chair
Jong Choi, MSW Program
Roseanna McCleary, MSW Program
From: Steve Suter, University Research Ethics Review Coordinator
Subject: Protocol 10-155: Authorization Following Exemption from Full Review

Anne Duran, Ph.D.
Department of Psychology
Scientific Concerns

Roseanna McCleary, Ph.D.
Masters of Social Work
Scientific Concerns

Thomas Blommers, Ph.D.
Department of Modern Languages
Nonscientific/Humanistic Concerns

Lily Alvarez, B.A.
Kern County Mental Health
Community Issues/Concerns

Grant Herndon
Schools Legal Service
Community Issues/Concerns

Tommy W. Tunson, J.D.
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Kathleen Gilchrist, Ph.D.
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Paul Newberry, Ph.D.
Department of Philosophy/
Religious Studies
Nonscientific/Humanistic Concerns
IRB/HSR Chair

Yunjoo Lee, Ph.D.
Department of Special Education
Nonscientific/Humanistic Concerns

Steve Suter, Ph.D.
Department of Psychology
Research Ethics Review Coordinator
and IRB/HSR Secretary

I am pleased to inform you that your protocol, "Prevention through Registration: An Analysis of the Creation, Implementation, and Maintenance of an Elder Abuse Registry", has been approved, following exemption from full review. This research activity was exempted as defined in Paragraph 46.101 of Title 45, Code of Federal Regulations based on the following criteria: (1) Research involving the use of [standardized] educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior, UNLESS: (a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, and (b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation. Approval is based on your materials received on 11-30-10.

This authorization is strictly limited to the specific activities that have been authorized by the IRB. If you want to modify these activities, notify the IRB in advance so proposed changes can be reviewed. If you have any questions, or there are any unanticipated problems or adverse reactions, please contact me immediately.

The following person[s], only, are authorized to interact with subjects in collecting data or obtaining informed consent. Investigator is responsible for ensuring that any assistants interacting with data having personal identifiers are HSPT certified.

**Human Subjects Protection Training Certified:
Courtney Morris [10-14-10], Jong Choi [11-04-02] & Roseanna McCleary [9-15-03]**

Any signed consent documents must be retained for at least three years to enable research compliance monitoring and in case of concerns by research participants. Consent forms may be stored longer at the discretion of the principal investigator [PI]. The PI is responsible for retaining consent forms. If the PI is a student, the faculty supervisor is responsible for the consent forms. The consent forms must be stored so that only the authorized investigators or representatives of the IRB have access. At the end of the retention period the consent forms must be destroyed [not re-cycled or thrown away]. Please destroy all audio tapes after scoring.

This authorization will be valid until the end of November 2011.


Steve Suter, University Research Ethics Review Coordinator

Appendix B

Interview Guide

Interview Guide

1. If money were no object, what would an ideal elder abuse registry look like to you?
2. What would you include?
3. Who would update and maintain the registry?
4. What agency, organization or department would manage it?
5. Tell me about any of the current resources that you know of that could be used as starting points to the creation of a California online elder abuse registry rather than starting from scratch?
6. What do you see as the major benefits?
7. What do you see as possible barriers?
8. Delaware recently established an online Elder abuse Registry, How do you feel about the idea of making an adult abuse registry available to the public online?

