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Dementia and elder abuse in domestic settings

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DEMENTIA AND ELDER ABUSE IN DOMESTIC SETTINGS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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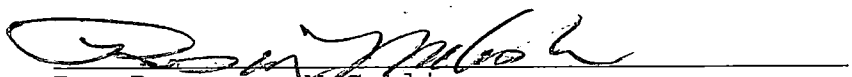

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ABSTRACT

America's growing elder population affects every segment of the social, political and economic landscape. This population has generated public concern and debate regarding the problems faced by this often-vulnerable group, including the issue of elder abuse. By the year 2030, an estimated twenty percent of the United States population will be sixty-five years of age or older. Currently, ten percent of this group is affected by dementia and with forty-seven percent of those older than eighty-five years, dementia is present (Parks, 2000). This research project examined associations between dementia and elder abuse in domestic settings utilizing secondary data obtained from Adult Protective Services of San Bernardino County

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CHAPTER ONE

INTRODUCTION

This chapter discusses the problem of elder abuse. It also examines elder abuse policy and the landmark National Elder Abuse Incidence Study. In addition, this chapter explores elder abuse in the context of social work practice, the purpose of this study, and the significance of the project for the social work profession.

Problem Statement

America's growing elder population affects every segment of the social, political, and economic landscape. This population has generated public concern and debate regarding the problems faced by this often-vulnerable group, including the issue of elder abuse. By the year 2030, an estimated twenty percent of the United States population will be sixty-five years of age or older. Currently, ten percent of this group is affected by dementia and with forty-seven percent of those older than eighty-five years, dementia is present (Parks, 2000).

This research project examined associations between dementia and elder abuse in domestic settings. This project sought to enhance the minimal body of knowledge that currently exists regarding this topic. It is vital

that people charged with protecting and serving the fast-growing elder population gain more understanding about abuse and other important issues that affect this dynamic group.

Policy Context

There are no national standardized definitions of elder abuse and state definitions vary considerably from one jurisdiction to another. Exacerbating this problem, researchers have utilized various definitions to study the issue. This problem, along with poor detection and underreporting, has contributed to a lack of reliable information relating to the actual incidence rate of elder abuse within the country (NCEA, 2001) [See Appendix A].

The lack of nationwide statistics has been a concern not only to elder abuse professionals but also to policy makers. With the passage of the 1992 amendments to the Family Violence Prevention and Services Act, the Department of Health and Human Services was mandated to conduct a complete study and investigation of the national incidence of abuse, neglect and exploitation of elderly persons (Wolfe, 2001).

The National Elder Abuse Incidence Study (NEAIS), a landmark study prepared for the Administration for Children and Families (ACF), the Administration on Aging

(AoA), and the Department of Health and Human Services (DHHS), explored the incidence of elder abuse and neglect in domestic settings during 1996. The NEAIS reported that as of 1996, "the best national estimate is that a total of 446,924 elder persons, aged sixty and over, experienced abuse and or neglect in domestic settings" (1998, p. 2). The NEAIS also concluded that, "for every reported incidence of elder abuse [and] neglect...approximately five go unreported" (1998, p. 1).

Over the years, federal policy has reflected the various constituencies that have laid claim to the issue of elder abuse. Public welfare laws, several crime bills, and various provisions of the Older Americans Act, have been national legislative responses to victims and their families. At the state level, laws addressing elder abuse and adult protective services are continually being amended to incorporate these new conceptualizations (Wolfe, 2001).

A new direction in elder abuse public policy is placing elder abuse within the context of family violence and the fight against crime. The declaration of family violence as a major public health and crime issue by the federal government in the late 1980s has had a positive impact on the family violence movement. The NCEA reported

that evidence that some forms of elder abuse qualify as family and intimate violence has made it possible to incorporate elder abuse within family violence initiatives. This also helped to create a broader constituency that includes representation from law enforcement, criminal justice, medicine, and domestic violence advocates (Wolfe, 2001).

Practice Context

Current social work practice is involved in micro, mezzo, and macro areas of elder abuse. However, because many of the factors that contribute to elder abuse are not well-understood, social workers may be uninformed or ill-equipped to serve this vulnerable population.

In fact, according to Wolfe (2001), the importance of cognitive status, including dementia, as a risk factor for elder abuse is still unclear. In addition, Wolfe reports that even though there have been studies of the relationship between elder abuse and dementia, the results are somewhat contradictory.

Social workers play a critical role in identifying, stopping, and preventing elder abuse. For example, Adult Protective Services (APS) workers are the front line workers in elder abuse prevention (National Committee to Prevent Elder Abuse [NCPEA], 2001).

A primary purpose of the county APS agency is to provide assistance to elderly and dependent adults who are functionally impaired, unable to meet their own needs, and who are victims of exploitation, neglect, and abuse (California Department of Social Services, 2001). County APS agency social workers investigate reports of abuse of elderly and dependent adults who are living in private homes, hotels, acute care hospitals, health clinics, adult day care and social day care centers.

In addition to providing a variety of other services, county APS agency social workers provide information and education to other agencies and the public about reporting requirements and other responsibilities under state and federal elder and dependent abuse reporting laws.

Purpose of the Study

The purpose of this study was to examine associations between dementia and elder abuse in domestic settings. In addition, it is the investigators' hope that this study will enhance the knowledge, and ultimately the skills, of professionals who serve the elderly population. This includes social workers in APS agencies as well as those who provide services in other micro, mezzo, and macro areas of practice.

Since county APS agencies are at the forefront of elder abuse reporting, this research project utilized a secondary analysis method using APS data in its exploration of associations between elder abuse and dementia in domestic settings.

Significance of the Project for Social Work Practice

This study is important because people charged with protecting and serving the elder population must gain a better understanding of elder abuse to aid in the development and implementation of meaningful prevention and intervention strategies and public policies. Because of the fast-growing elder population, which typically is under-served by social systems, increased understanding of the issues affecting elders is particularly needed.

In addition, research that explores issues for elders with dementia is also needed because of the prevalence of elderly individuals with cognitive impairment. For example, ten percent of the United States population over the age of sixty-five years is affected by dementia and with forty-seven percent of elders older than eighty-five years, dementia is present (Parks, 2000).

Hopefully, this study will serve to enhance the social work profession's understanding of elder abuse,

particularly in regard to elderly individuals affected by dementia. Increased understanding can result in more competent and effective practices for social workers at micro, mezzo and macro levels. Therefore, this study directly addressed the question: Are there associations between dementia and elder abuse in domestic settings?

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter examines dementia and elder abuse, risk factors for dementia, consequences of elder abuse, and human behavior in the social environment theories that guide research on elder abuse.

Dementia and Elder Abuse

A few studies have specifically explored the relationships between dementia in the elderly and domestic violence (i.e., Dyer, Pavlik, Murphy et al., 2000; Coyne & Reichman, 1993; Cooney & Mortimer, 1995). However, the national organization, Institute on Aging (IoA), which leads the federal effort on aging research, reported that despite several studies on the relationship between dementia and elder abuse, the results are somewhat contradictory. The IoA also reported that several studies have documented the relatively high prevalence of violence in families caring for elderly persons with dementia (Wolfe, 2001).

Older patients who have been abused or neglected have been found to have a significantly higher rate of depression and dementia, according to researchers in

Houston (Dyer et al., 2000). This study also found that patients who had been abused or neglected were far more likely to be diagnosed with dementia (51 percent) as opposed to patients who were not abused or neglected (30 percent). This research is the first published primary data study which demonstrates that the prevalence of the clinical diagnosis of dementia is increased in cases of elder abuse and neglect (Dyer et al., 2000).

Coyne's (1993) research has also found that mental health factors such as dementia increase the risk of abuse within a care-giving relationship. It is estimated that the prevalence of abuse of older adults suffering from dementia range from 5.4 percent in Paveza's study (as cited in Coyne, 2001) to 11.9 percent in Coyne's study (2001). These figures greatly exceed the 1 to 4 percent prevalence rates of abuse typically cited for elder adults.

Research by Lachs et al., (as cited in Coyne, 2001) studied a cohort of elderly adults over a nine year period and found that those individuals who suffer progressive declines in cognitive functioning are at particular risk for abuse. In addition, Teri et al., (as cited in Coyne, 2001), reported that behavioral disturbances, which are common to many elder individuals with dementia, may also

contribute to an association between elder abuse and dementia.

Notwithstanding the popular image of abuse arising from victims suffering from dementia and stressed caregivers, evidence is mounting that neither caregiver stress levels nor victim levels of dependence are core factors leading to elder abuse. Rather, indicators are that stress may be a contributing factor in cases of abuse but does not explain the phenomenon (Wolfe, 2001).

In another study Pillemer and Suitor (as cited in Coyne, 2001) examined the prevalence of violence within a sample of 236 primary caregivers for elders with dementia. The results indicated that 19.5 percent of caregivers surveyed had fears of becoming violent while providing care and 5.9 percent did engage in violent behavior while caring for an elder with dementia. Further, Coyne et al., (1993) in a study of 342 caregivers for elders with dementia, reported that 11.9 percent on at least one occasion pinched, shoved, bit, kicked or struck the cognitively impaired individual.

Risk Factors for Dementia

Dementia is characterized by a group of symptoms caused by gradual death of brain cells (Robinson, 1999).

The loss of cognitive abilities that occurs with dementia often leads to impairments in personality, memory, planning and reasoning (Robinson, 1999). The overwhelming majority of people with dementia are elderly, and the most common type of dementia is Alzheimer's disease and related disorders, followed by vascular or multi-infract dementia. Between 2 and 4 million Americans have been diagnosed with Alzheimer's disease and by the middle of the 21st Century, this number is expected to grow to as many as 14 million (Robinson, 1999).

An interesting study by Jorm explored occupation type as a predictor of cognitive decline and dementia in old age. The results, using cross-sectional analyses, revealed that the lowest test performance and highest prevalence of dementia were found in the low-status occupations. These occupations involve skilled trades, technical and some service occupations, farm workers, domestic service employees, and blue-collar workers (Jorm, 1999).

Jorm concluded that the differences between occupational groups were not due to cognitive decline, but that more likely it is "pre-morbid intelligence that accounts for the differences" (1999, p. 7). These results tend to confirm Mortimer's hypothesis that "psychosocial risk factors for dementia act primarily to increase

vulnerability, to reduce the margin of intellectual reserve to a level where a more modest level of brain pathology results in diagnosable dementia" (Mortimer as cited in Jorm, 1999, p. 7).

The National Elder Abuse Incidence Study (NEAIS) found that it was the "oldest old" (age 80 and over) that were disproportionately subjected to physical abuse and emotional abuse (1998). The finding reflected two to three times the rate of the population studied under the age of eighty years. These "elderly elders" are the ones most likely to suffer from some form of dementia, which afflicts 47 percent of those individuals older than 85 years. Eighty percent of elderly individuals with dementia are cared by family members in their home (Parks, 2000).

Other elder individuals that are especially vulnerable to abuse include those with dementia or confusion, those who are dependent on a caregiver, those who have a substance abuse problem, those who internalize blame and have excessive loyalty, and females (Kosberg, 1988). The dependence of the abuser on the victim, the mental state of the abuser, which may include emotional, psychiatric, and substance abuse problems, and a lack of external social supports for the victim, continue to

emerge as risk factors in studies of elder abuse (Wolfe, 2001).

Consequences of Elder Abuse

According to elder abuse literature there is little empirical data regarding the consequences to the victim of elder mistreatment. However, several case control studies have found that abused elders suffer from depression more frequently than non-abused elders (Dyer et al., 2000; Eyler, 1999).

In addition, some psychiatrists report that learned helplessness and alienation are potential major responses to abuse. The Institute on Aging reports that post-traumatic stress disorder may also be a consequence of physical and sexual abuse. Guilt, shame and fear are other effects often identified with mistreatment (Wolfe, 2001). In addition, substance abuse can exacerbate the consequences of dementia and elder abuse (Wolfe, 2001).

In one research study from Connecticut of 2,812 elderly subjects who had been reported to the state APS agency, a higher mortality rate was found compared to the control non-investigated group. The study concluded that no differences in mortality rates were found in the first few years but by the thirteenth year, only 11 percent of

the abused group was still alive versus 36 percent of the control non-investigated group (Wolfe, 2001).

Human Behavior in the Social Environment Theories Guiding Conceptualization

Researchers have offered various theoretical explanations of why elder abuse occurs. Theories include an overburdened caregiver (situational model), a dependent elder or perpetrator (exchange theory), a mentally/emotionally disturbed perpetrator (psychopathology), and a childhood of abuse and neglect [social learning theory] (Wolfe, 2001).

Others have criticized the emphasis on individual traits. They propose that structural forces such as the imbalance of power within relationships (feminist theory), or the marginalization of elders within society (political economic theory), have created conditions that lead to conflict and violence (Wolfe, 2001).

Family systems theory considers dynamics such as alcoholism's effect on the elderly and their families (Freidman, 1999), while political economic theory considers dynamics of job occupation (Jorm, 1998). Finally, the ecological model links many separate theories concerning elder abuse to broader social issues.

While the various theoretical approaches discussed, as well as family systems theory and person-in-environment theory, are meaningful to the study of elder abuse, an advantage of the ecological model is that it allows the phenomena to be linked to broader social issues, such as gender inequality. This is especially important, because of the high prevalence of elderly female abuse victims.

The Institute on Aging (IoA) reported that in an effort to accommodate the complexity and multiplicity of factors and theories associated with elder abuse, researchers such as Schiamberg and Gans (1999) and Carp (1999) have turned to an ecological model, first applied to child abuse and, more recently, to intimate partner violence (Wolfe, 2001). Wolfe, reported that in one iteration of this model, violence results from individual, interpersonal, and societal factors.

In the ecological model, "problems are seen as outcomes of the transaction of many complex variables [and] a feedback model of change is initiated in which interventions are made and tested through the continued monitoring of the system's response" (Hartmen & Laird, 1983, p. 72). Furthermore, interventions that redefine and thus alter the family's relationship system are evaluated in terms of outcome (Hartman & Laird, 1983).

A social work ecological perspective guides this research project. Consideration is given to some of the forces within and outside the client system as well as the transactions between these systems that contribute to the development and continuation of the problem of elder abuse. In addition, consideration is given to the forces that can assist in the development of a solution to the problem of elder abuse.

Summary

This chapter explored dementia and elder abuse, risk factors for dementia, consequences of elder abuse, and human behavior in the social environment theories that guide research on elder abuse.

CHAPTER THREE

METHODS

Introduction

This chapter will discuss methods utilized for this research project, including study design, sampling, protection of human subjects, and data collection and instruments. It will also discuss the data analysis methods used.

Study Design

This research study utilizes quantitative analysis of secondary data obtained from Adult Protective Services (APS) of San Bernardino County and examines associations between dementia and elder abuse in domestic settings. Data were collected and evaluated using a data extraction instrument (see Appendix B). The incidence of abuse among the elderly with dementia compared to elderly without dementia was evaluated.

The decision to utilize a secondary data analysis design was influenced by time and personnel limitations faced by the investigators of the study. This consideration was weighed against the facts that use of APS data may offer a restricted or limited point of view, and may have missing data.

However, the investigators deemed APS as a meaningful source for providing data because it is a leading agency utilized for reporting suspected elder abuse and is charged with providing a full range of services and activities necessary to prevent or remedy situations in which elderly adults are endangered or abused by the treatment of others.

Sampling

Using a data extraction instrument (Appendix B), a data set was obtained that included demographic variables such as age, gender, and ethnicity. All subjects were age 65 or older, and had suffered one or more forms of abuse (i.e., physical, sexual, emotional, financial, and neglect, as defined by APS). The sample consisted of sixty individual APS case files, chosen through a systematic random sampling method by the investigators from case files closed during the year 2001. The only criteria the investigators considered when selecting case files were that the individual represented was a minimum of 65 years of age.

The data set was used to examine the ratio of elderly abuse victims with dementia, compared to elderly abuse victims without dementia. The director of the San

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Bernardino Department of Aging and Adult Services Area Agency on Aging, and the APS managers at the Sun West office location cooperated in providing access to the APS case records.

Data Collection and Instruments

Data were collected from the case records of APS in San Bernardino County at the Sun West office location. Using a data extraction instrument (Appendix B), the demographic variables age, gender, ethnicity, and housing were recovered. Information regarding the independent variable suspected or confirmed presence of dementia, and the dependent variables of physical, sexual, emotional and financial abuse, and neglect, as defined by the APS agency, was examined using the case records information.

The variables extracted from the sample of sixty APS case files included dementia, significant cognitive impairment, age, ethnicity, gender, living accommodations, perpetrator's relationship to the victim, type(s) of elder abuse, services provided during APS involvement, and dates associated with case referral, assessment and closing. Each of these variables had a nominal level of measurement. In addition, the investigators extracted

information regarding the elder's age, which had an ordinal level of measurement.

Procedures

A contact letter outlining this research project was sent to the director of San Bernardino County Department of Aging and Adult Services. This individual provided written authorization for the investigators to access APS case records at the Sun West office location.

The investigators of the study visited the APS Sun West office in San Bernardino County on two occasions and obtained the necessary data. On each occasion, an APS manager was available to assist the investigators with any questions regarding case record information.

Protection of Human Subjects

The investigators made no direct contact with human subjects as this study utilized a secondary data analysis method (i.e., review of case records closed during the year 2001). While the investigators saw identifying information such as names and addresses, this information was kept confidential.

Data Analysis

Univariate and bivariate statistics were utilized to provide descriptive data and opportunities for explanatory

analysis. Frequency distributions, and measures of central tendency and dispersion were used on demographic and other data for descriptive analysis.

Chi-square tests were employed to examine associations between the independent variable and the dependent variables. T-tests and Pearson's r were used to examine any association between the variables as appropriate.

Summary

Using a research design of quantitative analysis of secondary data from Adult Protective Services (APS) of San Bernardino County this study explored and examined associations between dementia and elder abuse in a domestic setting. Evaluation was conducted regarding the incidence rate of abuse among elderly with dementia compared to elderly without dementia using a sample size of sixty, drawn randomly from APS case records located at the Sun West offices in San Bernardino County. This study utilized univariate and bivariate statistics to analyze data and to provide opportunities for explanatory analysis. Data analysis methods also included utilizing frequency distributions and measures of central tendency and dispersion, Pearson's r, t-test, and chi-square.

CHAPTER FOUR

RESULTS

Introduction

This chapter provides a presentation of the findings from this research project, which includes a demographic description of the sample. In addition, bivariate analysis regarding clients with dementia or significant cognitive impairment compared to those without these cognitive difficulties is provided in relation to types of reported elder abuse. Also, bivariate analyses are provided regarding clients that refused APS services compared to those that did not in relation to types of elder abuse reported, crisis intervention services, face-to-face interviews, and age groups. Last, this chapter concludes with a summary.

Throughout this chapter, the term "dementia" refers to clients with dementia or significant cognitive impairment. Importantly, while APS workers indicated the presence of cognitive difficulties in the elder's case file, it is possible that some workers may have done so incorrectly. Also, some APS workers may have neglected to indicate the presence of cognitive difficulties in the elder's case file.

Presentation of the Findings

Using a systematic random sampling method, secondary data were examined from sixty Adult Protective Services (APS) of San Bernardino County case files closed during 2001 from the Sun West office. The sample consisted of 39 females and 21 males ranging in age from 65 to 99 years (mean = 83). Of this group, most were between the ages of 65 and 80 years (56.7%) while the remainder were 81 years of age or older (43.3%).

The majority of clients were Caucasian (76.8%), while ethnic minority groups (i.e., Hispanic/Latino and African-American) represented 23.2%. There was no representation for Asian/Pacific Islander, or any other ethnic group category. When combined, clients with dementia (n = 20) or significant cognitive impairment (n = 10) represented half of the sample, while those without these cognitive difficulties (n = 30) constituted the remaining half.

The most prevalent type of elder abuse reported in the sample was physical abuse by self (n = 34), followed by self-neglect (N = 30), and financial abuse by other(s) [n = 14]. Emotional abuse by other(s) [n = 12] and physical abuse by other(s) [n = 12] represented the fourth most prevalent types of elder abuse reported.

Dementia

Bivariate analyses were conducted regarding clients with and without dementia and all other variables examined in this study (see Appendix D, Table 1). Chi-square results did not yield any statistically significant findings. Therefore, whether a client presented with dementia or not, there were no meaningful differences in regard to demographic characteristics, perpetrator(s) relationship to the victim, type(s) of APS services provided, client refusal of services, or case processing timeframes.

Bivariate analyses were also conducted regarding clients with dementia and the type of elder abuse reported (see Appendix D, Table 1). While chi-square results did not yield any statistically significant differences between these groups, the investigators have provided a brief summary ranking the four most prevalent types of abuse reported for each:

For clients either with or without dementia, the most prevalent type of abuse reported was physical abuse by self (n = 21 and n = 14 respectively), followed by self-neglect (n = 18 and n = 12). However, the third most prevalent type of elder abuse reported was different for each group. For example, ranking third for clients with

dementia was physical abuse by other(s) [n = 8 versus n = 4 without dementia], while emotional abuse by other(s) ranked third for clients without dementia (n = 8 versus n = 4 with dementia).

The fourth most prevalent type of abuse for each group was financial abuse by other(s) [n = 7 and n = 7 without dementia].

Client Refusal of Services

Bivariate analyses were conducted regarding clients that refused APS services and all other variables examined in this study (see Appendix D, Table 2). Chi-square results yielded only one type of abuse, self neglect, as statistically significant. Clients with reported self-neglect were more likely to refuse APS services than were other clients (see Table 1).

Table 1. Refused Services and Self-Neglect

		Self-Neglect Yes(n)	No(n)	Total
Refused APS Services	Yes(n)	11	3	14
	No(n)	19	27	46
Total		30	30	60

Chi-Square (χ^2 = 5.963, df = 1, p = .015)

Two types of APS intervention were significantly associated with service refusal: crisis intervention and face-to-face interview. Clients that received crisis intervention services were less likely to refuse additional APS services than were other clients (see Table 2).

Table 2. Refused Services and Crisis Intervention

		Crisis Intervention Yes(n)	No(n)	Total
Refused APS Services	Yes(n)	14	14	
	No(n)	11	35	46
Total		11	49	60

Chi-square (χ^2 = 4.099, df = 1, p = .043)

Clients that received a face-to-face interview with an APS worker were less likely to refuse services than other clients, although the association did not reach statistical significance (see Table 3).

Table 3. Refused Services and Face-to-Face Interview

		Face-to-Face Interview Yes(n)	No(n)	Total
Refused APS Services	Yes(n)	7	7	14
	No(n)	34	12	46
Total		41	19	60

Chi-square (χ^2 = 2.836, df = 1, p = .092)

For other client characteristics only age was associated with refusal of APS services. The chi-square for this association approached statistical significance. Older clients (between 81 and 99 years of age) were more likely to refuse APS services than were younger clients (between 65 to 80 years of age) [see table 4].

Table 4. Refused Services and Age Group

		Age Group (years) 65 to 80(n)	81 to 99(n)	Total
Refused APS Services	Yes(n)	5	9	14
	No(n)	29	17	46
Total		34	26	60

Chi-square (χ^2 = 3.265, df = 1, p = .071)

Summary

This chapter provided a presentation of the findings from this research project, which included a demographic description of the sample. Also, bivariate analyses regarding clients with dementia compared to those without were provided in relation to types of reported elder abuse. In addition, bivariate analyses were reported for clients that refused APS services compared to those that did not in relation to types of reported elder abuse, crisis intervention services, face-to-face interviews, and age groups.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter presents conclusions and interpretations drawn from the statistical analysis of data from Adult Protective Services (APS) case files. Results that do not support findings cited in the literature review, or that are unanticipated, are discussed with possible explanations. Implications of the results for future APS social work practice with elderly clients with and without dementia, suggestions for further research, as well as study limitations are explored. Finally, conclusions affecting social work practice and policy are discussed.

Throughout this chapter, the term "dementia" refers to clients with dementia or significant cognitive impairment unless otherwise stated.

Discussion

Analyses of data gathered from sixty APS case files did not yield any statistically significant results regarding elderly clients with and without dementia in relation to type(s) of abuse reported, type(s) of services provided, or client refusal of APS services. In addition, there were no statistically significant results regarding

these two groups in relation to perpetrator(s) relationship to the victim, or case processing timeframes.

However, there were two statistically significant findings when examining the APS client population as a whole. First, clients that refused APS services were more likely to have self-neglect reported. Second, clients that received crisis intervention services were less likely to refuse additional APS services.

In addition, there were two findings that approach statistical significance. First, clients that received a face-to-face interview with an APS worker were less likely to refuse services. Second, older clients (between 81 to 99 years of age) were more likely to refuse APS services.

Regarding self-neglect and client refusal of APS services, Berger (1994) points out that this situation is part of an unfortunate pattern. The more frail and troubled the elderly client is the less able they are to advocate for themselves and secure available services that they need. Therefore, most of the services go to the relatively less needy seniors (Zopf as cited in Berger, 1994).

The NEAIS report states that "if there is minimal contact between the elderly person and [the APS worker], the opportunities for observing the signs and symptoms of

abuse and neglect are lessened" (1998. Chp. 5, p. 5). It was observed that APS worker case notes frequently indicated that the elder would refuse to talk to the worker, or would speak to the worker in such a limited manner that either APS services were not offered or the client simply refused services. Lack of communication and rapport can encourage the refusal of APS services by the client, even though they may be in desperate need of services and personal assistance. Therefore, it is vital that effective communication and rapport be established between the worker and the client. Further training for APS workers in techniques for communicating and building rapport with such reluctant clients may be helpful.

It was also observed that some APS workers were much younger than the clients they were trying to assist. Therefore, further training may be helpful in regard to the unique issues and needs of older elders since older clients were more likely to refuse APS services than were younger clients.

The cases reviewed involved men and women 65 to 99 years of age. This generation, born in the earlier years of the Twentieth Century, lived a childhood possibly threatened by the hunger and poverty of the Depression, and as young adults, faced World War II. In his book, "The

Greatest Generation," Brokaw (1998) eloquently describes this now elder population stating, "At a time in their lives when their days and nights should have been filled with innocent adventure, love [and] the workaday world [they] answered the call to save the world", and by the millions risked their lives in World War II. Brokaw also makes a point that has great bearing on the lack of rapport noted between APS workers and the elder clients they are trying to help: "This generation was united not only by a common purpose, but also by common values—duty, honor, economy [and] above all, responsibility for oneself" (1998).

Berger also comments on this elder generations' independence, stating that for these individuals, the goal is not always length of life, but a crucial quality of life in which many seek to continue living as independently as possible (1994). Many elders don't want to "burden" their children with the responsibility of primary caregiver, nor do they want to enter a nursing home. Brokaw concurs, explaining that the "Greatest Generation" created "interesting and useful lives and the America we have today [and] they now reach the twilight of their adventurous and productive lives" (1998). Perhaps tragically, this generation of success and independence

were ready to handle anything except being elderly and frail.

As previously noted, another finding of this research project is that a face-to-face interview between an APS worker and client leads to less likelihood of the elder refusing services. If the APS worker were able to approach the client with more understanding about this generations' socio-cultural background (such as awareness that they hold a strong sense of pride, highly prize their independence, and may associate APS services with "welfare") this might lessen the likelihood of the elder refusing services. In addition, since America's elder population is comprised of diverse ethnic groups, including many immigrants, further training for workers regarding cultural influences among different ethnic groups may also be helpful.

Further, a great deal of assistance could come from the retired elderly themselves. Working as trained volunteers, an elder "peer counselor" could accompany an APS worker at the time of assessment and face-to-face interview. Not only could these elder peer counselors help introduce the concept of a "caseworker" and "services" into the clients life, but also reassure the them that by accepting APS services they are not shaming themselves.

The elder volunteer could also provide peer support, perhaps through a continuing schedule of "friendly visits" if the need is there.

The second finding of statistical significance is an association between crisis intervention and refusal of APS services. None of the clients that received crisis intervention services refused additional APS services. The fact that all of these elders accepted APS services makes this the only statistically significant finding that demonstrates a positive client response. However, it could not always be determined from case notes if the worker determined the client was in crisis, or if the client initiated APS assistance with a crisis situation. Therefore, it is not clear why this response is occurring.

One possible explanation is that APS workers are interacting differently with elders in a crisis situation that helps encourage them to accept APS services. Or, perhaps the clients themselves are more prepared to accept APS services due to the gravity of their situation.

Berger provides another possible explanation for this finding. She points out that medical advances have increased the number of older elderly people in society however, the medical establishment focuses on the "dramatic, life-saving intervention rather than on the

prevention and treatment of chronic illness" from which many elderly people suffer (1994, p. 666). Yet, it is the chronic problems, such as dementia, that so often take a toll on the elder's strength, pride, and independence (Berger, 1994).

Could APS workers embrace the same attitude as the medical establishment? If so, are APS workers then geared toward and better prepared for serving the elderly client in crisis more than the common situation of the client with chronic problems? This is an area requiring more in-depth research, and has implications for the possible increase of client acceptance of services in other areas.

Limitations

Because APS case files from the San Bernardino County Sun West office location were the only source of data this project used, it is possible that a limited or restricted point of view about client problems is reflected in the results. Further, while a systematic random sampling method was used in conjunction with a data extraction instrument, each case file examined did not necessarily provide all the information sought. There were gaps in client information, as well as subsequent actions taken by the APS worker. While all the APS case files had

standardized forms to be completed by the worker, they appeared to be completed in a non-standardized, "hit-or-miss" fashion.

Another potential limitation is that the small number of ethnic minorities in the sample restricted analysis of ethnic differences to Caucasians versus "people of color". Similar problems were encountered in the relationship of the primary caregiver to the client, which also required combining categories and restricted potentially valuable detailed analysis.

Recommendations for Social Work Practice, Policy and Research

The results of this study suggest increased training of APS workers is needed in dealing with diverse and dynamic populations. A program of elderly volunteer peer counselors working in association with APS workers is recommended, particularly in light of the high refusal rate of services by elderly clients. A program such as this could greatly assist in establishing rapport and effective communication between the APS worker and elderly client.

The results also suggest a need for continuing support and follow-up services for the victims of elder abuse. Berger (1994) proposes a new focus by the medical

community (including APS) on relieving or preventing nonfatal diseases among and abuse of the elderly. This policy would greatly decrease the frailty of the elderly, especially among those 81 years of age or older that so often experience a poorer overall health than their younger counterparts.

Berger uses the same argument in regard to America's political process and social policy toward the elderly. She states that by failing to ensure "ready and timely access to measures that could prevent or reduce their impairment [or abuse], we increase frailty among the elderly" and place them at risk in abusive situations (1994, p. 666).

Finally, it was unclear when reviewing APS case files what services were or were not offered the client. It was also unclear if all services were offered equally to all clients. Therefore, the results of this study suggest that APS workers review the proper completion of APS forms to ensure reliable, standardized information is contained in every case file.

In addition, confusion and incongruent notations within APS worker notes and forms were observed regarding whether or not an elderly client presented with dementia or some form of a significant cognitive impairment. For

example, in some areas of a single case file the worker indicated the elder presented with dementia while in another area of the same file he or she indicated no cognitive difficulties. This was true for entries that appear to be relating to the same date of contact with the client. Therefore, it is suggested that a clearly operationalized definition of dementia and of significant cognitive impairment be utilized.

APS might also benefit from forming liaisons with private corporations and community agencies and organizations (e.g., Rotary Clubs, Senior Citizen Organizations) to provide more comprehensive outreach programs and support to the elderly community. These alliances may provide a valuable source for recruiting elderly peer counselors as described previously in this chapter.

Conclusions

This study did not yield any statistically significant results regarding elderly clients with dementia compared to those without, in relation to demographic characteristics, type(s)of abuse reported, type(s) of services provided, client refusal of APS services, or case processing timeframes. However, in

regard to clients that refused APS services, statistically significant results were focused in relation to self-neglect, crisis intervention, face-to-face interviews, and age groups.

As a result of these findings, suggestions were made for APS workers serving the diverse and dynamic elder population. These suggestions included trained elder volunteer peer counselors, regularly scheduled friendly visits by these volunteers, and building liaisons with private companies and community organizations to enhance outreach programs.

In addition, suggestions regarding continued training for APS workers in areas such as age group, socio-cultural, and ethnic diversity, dementia and significant cognitive impairment, and case notes and forms processing were also provided. Also, the use of operationalized definitions of dementia and other forms of cognitive difficulties was suggested.

Exploration of elder clients experiencing crisis and the ways in which APS workers interact with them, certainly merits further research. In addition, the use of standardized procedures was recommended for providing services for elder clients that present with dementia or some form of significant cognitive impairment.

In conclusion, since individuals 85 years of age or older, are the fastest growing population in the United States, it is important that APS workers, and other social workers and professionals providing services to this diverse population, familiarize themselves with the unique issues and needs of this group (NEAIS, 1998). In addition, it is appropriate that all fifty states adopt standardized reporting practices for elder abuse using the same operational definitions. A consistency among the states can help ensure faster response to an at-risk elder. It can also serve to provide data to enhance understanding of elder abuse and aid in the development and implementation of meaningful prevention and intervention strategies and public policies (NEAIS, 1998).

The questions and suggestions this report offers comes from the heart of the beginnings of the social work profession, when it was agreed that social workers have a responsibility not just to provide equal treatment for each client, but to advocate for the policy and social changes that will allow equal treatment for every individual.

APPENDIX A

NATIONAL CENTER ON ELDER ABUSE

INCIDENCE RATE OF ELDER ABUSE

IN THE UNITED STATES

NATIONAL CENTER ON ELDER ABUSE INCIDENCE RATE FOR ELDER ABUSE IN THE UNITED STATES

The National Center on Elder Abuse (NCEA) defines seven different types of elder abuse; physical abuse; sexual abuse; emotional abuse; financial exploitation; neglect; abandonment; and self-neglect. These definitions are based on an analysis of existing state and federal definitions of elder abuse, neglect, and exploitation conducted by the NCEA in 1995 (NCEA, 2001). Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act (NCEA, 2001).

The NCEA reported that in 1991 researchers estimated that approximately 2.5 million people were victims of various forms of elder abuse. This figure was adjusted in 1996, based on state reporting data suggesting that there are between 820,000 and 1,860,000 abused elders in the country (NCEA, 2001).

APPENDIX B

DATA EXTRACTION INSTRUMENT

ADULT PROTECTIVE SERVICES DATA EXTRACTION INSTRUMENT

Dementia:

(1) Yes
(2) No

Significant Cognitive Impairment:

(1) Yes
(2) No

Age:

(1) 65 to 70 years
(2) 71 to 80 years
(3) 81 to 90 years
(4) 91 years or older

Ethnicity:

(1) Caucasian
(2) Hispanic/Latino
(3) African-American
(4) Asian/Pacific Islander
(5) Other

Gender:

(1) Female
(2) Male

Living Accommodations:

(1) Own home/independent living
(2) Own home/lives with other(s)
(3) Lives in private home of other(s)
(4) Rented home/apartment/mobile home/ lives independently or with other(s)

Perpetrator(s):

(1) No identified perpetrator(s)
(2) Perpetrator lives in home
(3) Perpetrator does not live in home

Perpetrator(s) Relationship to Victim:

(1) Caregiver/family member
(2) Non-caregiver/family member
(3) Caregiver/non-family member
(4) Non-caregiver/non-family member

Type of Elder Abuse:

By Other(s):
(1) Physical
(2) Sexual
(3) Emotional
(4) Financial
(5) Neglect

By Self:
(6) Physical
(7) Financial
(8) Neglect
(9) Missing

Services Provided During APS Involvement:

(1) Face-to-face interview with client
(2) Client advocacy
(3) Assistance with appropriate living arrangement
(4) Crisis intervention
(5) Family counseling
(6) Provision of necessities
(7) Transportation
(8) Referral to other agencies
(9) Missing

Dates:

(1) Referral to assessment
(2) Assessment to close
(9) Missing

Refused Services:

(1) Yes
(2) No
(3) Missing

APPENDIX C

STATE OF CALIFORNIA ADULT PROTECTIVE SERVICE DEFINITIONS OF ELDER OR DEPENDENT ADULT ABUSE

STATE OF CALIFORNIA ADULT PROTECTIVE SERVICE DEFINITIONS OF ELDER OR DEPENDENT ADULT ABUSE

For the purposes of these definitions, the term "elder" refers to any person residing in the state of California who is 65 years of age or older (WIC 15610.27).

Emotional/Psychological Abuse (a.k.a., Mental Suffering) (WIC 15610.53) means fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by threats, harassment, or other forms of intimidating behavior.

Financial Abuse (WIC 15610.30) means a situation in which one or both of the following apply:

(A) A person, including but not limited to, one who has the care or custody of, or who stands in a position of trust to, an elder or a dependent adult, takes, secretes, or appropriates their money or property, to wrongful use, or with intent to defraud.

(B) A situation in which all of the following conditions are satisfied:

1) An elder (who would be a dependent adult if he or she were between the ages of 18 and 64) or dependent adult or his or her representative, requests that a third party transfer to the elder or dependent adult or to his or her representative, or to a court appointed receiver, property that meets all of the following criteria:

(a) The third party holds or has control of the property.

(b) The property belongs to, or is held in express trust, constructive trust or resulting for, the elder or dependent adult.

(c) The ownership or control of the property was acquired in whole or part by the third party or someone acting in concert with the third party from the elder or dependent adult at a time

when the dependent adult was a dependent adult or was a person who would have been a dependent adult if he or she was between the ages of 18 and 64.

2) Despite the request for the transfer of property, the third party without god cause either continues to hold the property of fails to take reasonable steps to make the property readily available to the elder or dependent adult, to his or her representative or to a court appointed receiver.

3) The third party committed acts described in this paragraph in bad faith. A third party shall be deemed as having acted in bad faith if the third party either knew or should have known that the elder or dependent adult had right to have the property transferred or made readily available. For the purpose of this subdivision, a third party should know of this right if, on the basis of the elder or dependent adult's representative, it is obvious to a reasonable person that the elder or dependent adult had this right.

(For the purpose of this definition, the term "third party" means a person who holds or has control of property that belongs to or is held in express trust, constructive trust or resulting trust for an elder or dependent adult. For the purposes of this definition, the term "representative" means an elder or dependent adult's conservator of the estate, or attorney-in-fact acting within the authority of the power of attorney.)

Neglect (WIC 15610.57) means either of the following:

(A) The negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(B) The negligent failure of the person themselves to exercise that degree of care that a

reasonable person in a like situation would exercise.

Neglect includes, but is not limited to, all of the following:

1) Failure to assist in personal hygiene, or in the provision of food, clothing or shelter.

2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

3) Failure to protect from health and safety hazards.

4) Failure to prevent malnutrition or dehydration.

5) Failure of a person to provide the needs specified in paragraphs 1) to 4), inclusive, for themselves due to ignorance, illiteracy, incompetence, mental limitation, substance abuse, or poor health.

Physical Abuse (WIC 15610.63) means all of the following:

(A) Assault, as defined in Section 240 of the Penal Code.

(B) Battery, as defined in Section 242 of the Penal Code.

(C) Assault with a deadly weapon or force likely to produce great bodily injury, as defined by Section 245 of the Penal Code.

(D) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.

(E) Sexual Assault, which means any of the following:

1) Sexual battery, as defined in Section 243.4 of the Penal Code.

2) Rape, as defined in Section 261 of the Penal Code.

3) Rape in concert, as defined in Section 264.1 of the Penal Code.

4) Spousal rape, as defined in Section 262 of the Penal Code.

5) Incest, as defined in Section 285 of the Penal Code.

6) Sodomy, as defined in Section 286a of the Penal Code.

7) Oral copulation, as defined in Section 288a of the Penal Code.

8) Penetration of a genital or anal opening by a foreign object, as defined in Section 289 of the Penal Code.

(F) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:

1) For punishment.

2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician or surgeon licensed in the State of California who is providing medical care to the elder or dependent adult at the time the instructions are given.

3) For any purpose not authorized by the physician and surgeon.

APPENDIX D

STATISTICS SUMMARY

TABLE 1: DEMENTIA AND SIGNIFICANT COGNITIVE IMPAIRMENT

	% Total Sample	(N)
Cognition		
Dementia	33.3	20
SCI	16.7	10
Neither	50.0	30

	% Total Sample	(N)	Dementia and Significant Cognitive Impairment % Yes	(N)	% No	(N)
Gender						
Male	35.0	21	40.6	13	28.6	8
Female	65.0	39	59.4	19	71.4	20
			Chi-square (χ^2 = .954, df = 1, p = .329)			
Age						
65 to 70	18.3	11	18.8	6	17.9	5
71 to 80	36.7	22	34.4	11	39.3	11
81 to 90	33.3	20	37.5	12	28.6	8
91 or older	11.7	7	9.4	3	14.3	4
			Chi-square (χ^2 = .771, df = 3, p = .857)			
65 to 80	56.7	34	53.1	17	60.7	17
81 or older	43.3	26	46.9	15	39.3	11
			Chi-square (χ^2 = .350, df = 1, p = .554)			
Ethnicity						
Caucasian	76.8	43	74.2	23	80.0	20
People of Color	23.2	13	25.8	8	20.0	5
			Chi-square (χ^2 = .262, df = 1, p = .609)			

	% Total Sample	(N)	Dementia and Significant Cognitive Impairment % Yes	(N)	% No	(N)
Abuse by Other(s)						
Physical	20.0	12	66.7	8	33.3	4
			Chi-square (χ^2 = 1.071, df = 1, p = .301)			
Emotional	20.0	12	33.3	4	66.7	8
			Chi-square (χ^2 = 2.411, df = 1, p = .121)			
Financial	23.3	14	50.0	7	50.0	7
			Chi-square (χ^2 = .082, df = 1, p = .775)			
Neglect	13.3	8	62.5	5	37.5	3
			Chi-square (χ^2 = .312, df = 1, p = .433)			
Abuse by Self						
Physical	56.7	34	61.8	21	38.2	13
			Chi-square (χ^2 = 2.241, df = 1, p = .134)			
Financial	11.7	7	71.4	5	28.6	2
			Chi-square (χ^2 = 1.043, df = 1, p = .307)			
Neglect	50.0	30	60.0	18	40.0	12
			Chi-square (χ^2 = 1.071, df = 1, p = .301)			

	% Total Sample	(N)	Dementia and Significant Cognitive Impairment % Yes	(N)	% No	(N)
Perpetrator(s)						
No identified perpetrator(s)	3.5	2	100.0	2	0.0	0
Perpetrator(s) lives in home	75.4	43	53.5	23	46.5	20
Perpetrator(s) does not live in home	19.3	11	54.5	6	45.5	5
			Chi-square (χ^2 = 2.478, df = 3, p = .479)			
Perpetrator(s) Relationship to Victim						
Caregiver (family/non-family)	24.1	14	50.0	7	50.0	7
Non-caregiver (family/non-family)	75.9	44	52.3	23	47.7	21
			Chi-square (χ^2 = .022, df = 1, p = .882)			

	% Total Sample	(N)	Dementia and Significant Cognitive Impairment % Yes	(N)	% No	(N)
Services Provided						
Face-to-face interview	68.3	41	53.7	22	46.3	19
			Chi-square (χ^2 = .006, df = 1, p = .941)			
Crisis IIntervention	18.3	11	63.6	7	36.4	4
			Chi-square (χ^2 = .574, df = 1, p = .448)			
Transportation	1.7	1	0.0	0	100.0	1
			Chi-square (χ^2 = 1.162, df = 1, p = .281)			
Referral to Other agencies	3.3	2	50.0	1	50.0	1
			Chi-square (χ^2 = .009, df = 1, p = .923)			
Provision of necessities	1.7	1	100.0	1	0.0	0
			Chi-square (χ^2 = .890, df = 1, p = .346)			
Family Counseling	6.7	4	50.0	2	50.0	2
			Chi-square (χ^2 = .019, df = 1, p = .890)			
Client Advocacy	11.7	7	0.0	0	100.0	7
			(no measure of association)			
Assistance with living arrangements	6.7	4	75.0	3	25.0	1
			Chi-square (χ^2 = .808, df = 1, p = .369)			

	% Total Sample	(N)	Dementia and Significant Cognitive Impairment % Yes	(N)	% No	(N)
Refused Services	23.3	14	57.1	8	42.9	6
			Chi-square (χ^2 = .106, df = 1, p = .744)			
Living Accommodations						
Own home/ independent living	32.0	16	50.0	8	50.0	8
Own home/lives Other(s) or lives in Other(s) home	40.0	20	55.0	11	45.0	9
Rented home/ Apartment/mobile home/lives independently or with other(s)	28.0	14	64.3	9	35.7	5
			Chi-square (χ^2 = .632, df = 1, p = .729)			

	% Total Sample	(N)	Dementia and Significant Cognitive Impairment % Yes	(N)	% No	(N)
Case Processing Timeframes						
Referral to Assessment						
within 1 week	58.6	34	58.8	20	41.2	14
within 2 weeks	28.0	14	64.3	9	35.7	5
within 3 weeks	8.6	5	20.0	1	0.0	0
within 4 weeks	1.7	1	100.0	1	0.0	0
within 1 month or more	1.7	1	0.0	0	100.0	1
			Chi-square (χ^2 = 4.819, df = 4, p = .306)			
Assessment to Closing						
within 2 weeks	31.6	18	61.1	11	38.9	7
within 1 month	38.6	22	63.6	14	36.4	8
within 2 months	19.3	11	36.4	4	63.6	7
within 6 months	10.5	6	33.3	2	66.7	4
			Chi-square (χ^2 = 3.599, df = 3, p = .308)			

TABLE 2: CLIENT REFUSAL OF APS SERVICES

	% Total Sample	(N)
Refused Services	23.3	14

	% Total Sample	(N)	Client Refused Services % Yes	(N)
Gender				
Male	35.0	21	28.6	4
Female	65.0	39	71.4	10
			Chi-square (χ^2 = .332, df = 1, p = .565)	
Age				
65 to 70	18.3	11	7.1	1
71 to 80	36.7	22	28.6	4
81 to 90	33.3	20	57.1	8
91 or older	11.7	7	7.1	1
			Chi-square (χ^2 = 5.000, df = 3, p = .172)	
65 to 80	56.7	34	35.7	5
81 or older	43.3	26	64.3	9
			Chi-square (χ^2 = 3.265, df = 1, p = .071)	
Ethnicity				
Caucasian	76.8	43	92.3	12
People of Color	23.2	13	7.7	1
			Chi-square (χ^2 = 2.288, df = 1, p = .130)	
Cognition				
Dementia/SCI	50.0	30	57.1	8
Neither	50.0	30	42.9	6
			Chi-square (χ^2 = .106, df = 1, p = .744)	

	% Total Sample	(N)	Client Refused Services % Yes	(N)
Abuse by Other(s)				
Physical	20.0	12	14.3	2
			Chi-square (χ^2 = .373, df = 1, p = .542)	
Emotional	20.0	12	7.1	1
			Chi-square (χ^2 = 1.877, df = 1, p = .170)	
Financial	23.3	14	7.1	1
			Chi-square (χ^2 = 2.676, df = 1, p = .102)	
Neglect	13.3	8	0.0	0
			Chi-square (χ^2 = 2.809, df = 1, p = .102)	
Abuse by Self				
Physical	56.7	34	71.4	10
			Chi-square (χ^2 = 1.621, df = 1, p = .203)	
Financial	11.7	7	0.0	0
			Chi-square (χ^2 = 2.412, df = 1, p = .120)	
Neglect	50.0	30	78.6	11
			Chi-square (χ^2 = 5.963, df = 1, p = .015)	

	% Total Sample	(N)	Client Refused Services % Yes	(N)
Perpetrator(s)				
No identified perpetrator(s)	3.5	2	0.0	0
Perpetrator(s) lives in home	75.4	43	85.7	12
Perpetrator(s) Does not live in home	19.3	11	7.1	1
			Chi-square (χ^2 = 5.403, df = 3, p = .145)	
Perpetrator(s) Relationship to Victim				
Caregiver (family/non-family)	24.1	14	14.3	2
Non-caregiver (family/non-family)	75.9	44	85.7	12
			Chi-square (χ^2 = .978, df = 1, p = .323)	

Services Provided	% Total Sample	(N)	Client Refused Services % Yes	(N)
Face-to-face interview	68.3	41	50.0	7
			Chi-square (χ^2 = 2.836, df = 1, p = .092)	
Crisis intervention	18.3	11	0.0	0
			Chi-square (χ^2 = 4.099, df = 1, p = .043)	
Transportation	1.7	1	0.0	0
			Chi-square (χ^2 = .310, df = 1, p = .578)	
Referral to Other agencies	3.3	2	0.0	0
			Chi-square (χ^2 = .630, df = 1, p = .427)	
Provision of necessities	1.7	1	0.0	0
			Chi-square (χ^2 = .310, df = 1, p = .578)	
Family Counseling	6.7	4	0.0	0
			Chi-square (χ^2 = 1.304, df = 1, p = .253)	
Client Advocacy	11.7	7	0.0	0
			(no measure of association)	
Assistance with living arrangements	6.7	4	0.0	0
			Chi-square (χ^2 = 1.304, df = 1, p = .235)	

	% Total Sample	(N)	Client Refused Services % Yes	(N)
Living Accommodations				
Own home/ independent living	32.0	16	46.2	6
Own home/lives Other(s) or lives in Other(s) home	40.0	20	38.5	5
Rented home/ Apartment/mobile home/lives independently or with other(s)	28.0	14	15.4	2
			Chi-square (χ^2 = 2.109, df = 2, p = .348)	
Case Processing Timeframes				
Referral to Assessment				
within 1 week	58.6	34	57.1	8
within 2 weeks	28.0	14	28.6	4
within 3 weeks	8.6	5	7.1	1
within 4 weeks	1.7	1	7.1	1
within 1 month or more	1.7	1	0.0	0
			Chi-square (χ^2 = 3.518, df = 4, p = .475)	
Assessment to Closing				
within 2 weeks	31.6	18	28.6	4
within 1 month	38.6	22	57.1	8
within 2 months	19.3	11	7.1	1
within 6 months	10.5	6	7.1	1
			Chi-square (χ^2 = 3.330, df = 3, p = .344)	

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Team Effort: Karen Ann Anderson and Ann Watschke-Dixon

2. Data Entry and Analysis:

   Team Effort: Karen Ann Anderson and Ann Watschke-Dixon

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Karen Ann Anderson and Ann Watschke-Dixon

   b. Methods

      Team Effort: Karen Ann Anderson and Ann Watschke-Dixon

   c. Results

      Assigned Leader: Ann Watschke-Dixon
      Assisted By: Karen Ann Anderson

   d. Discussion

      Assigned Leader: Karen Ann Anderson
      Assisted By: Ann Watschke-Dixon