

# FULL REPORT

“We See Things Other People Aren’t Going to See”:  
Facilitators and Barriers to Screening and Management  
of Elder Abuse by Tribal Health Care Providers

## A National Needs Assessment

**THE INTERNATIONAL ASSOCIATION FOR INDIGENOUS  
AGING**

2019

*The National*  
**RESOURCE CENTER**  
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### **About IA2**

The International Association for Indigenous Aging, a 501(c)3 non-profit educational association, works to:

(1) Ensure the provision of appropriate and quality services and resources for indigenous elders;

- (2) Expand opportunities for elders' involvement in environmentalism, community participation, health maintenance, volunteerism/civic engagement, consumerism, senior enterprise;
- (3) Enhance the protection of the rights of elders including their freedom from abuse and neglect and their right to autonomy;
- (4) Educate the public, policymakers and practitioners about the status of indigenous elders; and
- (5) Improve the status of older people worldwide, especially indigenous populations.

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## Executive Summary

The International Association for Indigenous Aging (IA2), with funding from The National Resource Center for Reaching Victims of Crime, sought to understand the current needs and experiences of tribal health care clinics in screening and managing elder abuse among American Indian and Alaska Native (AIAN) older adults. This is the first and most comprehensive national needs assessments designed to identify facilitators and barriers for screening and management of elder abuse by tribal health care providers.

The project was developed based upon the belief that the diverse cultural, social, and health needs of tribal elders who are affiliated with or health care providers who serve the 573 federally recognized American Indian tribes and Alaska Native Villages in the United States (U.S.) (Bureau of Indian Affairs, n.d.) create a unique context in which to understand the recognition and management of elder abuse in outpatient clinical practice.

The state of the science on elder abuse among AIAN people is similar to that of other minority and vulnerable groups; it is limited, progress has been slow, and solid comparable prevalence estimates are lacking (Jervis & Sconzert-Hall, 2017; Sapra et al., 2014). The available research demonstrates a potentially high prevalence of abuse of AIAN elders that occurs at the intersection of contextual factors that include inter-tribal cultural diversity, tribal sovereignty, complex tribal justice systems, historical trauma, acculturation, urban migration, and demographic and health disparities (Crowder, Burnett, Laughon, & Driesbach, 2019; Crowder et al., 2019).

Health care providers in the United States (U.S.) are uniquely positioned to take an active role in addressing the epidemic of abuse and violence targeting elders.

Though, little screening for elder abuse actually occurs. Perhaps owing to a host of barriers or related to the continued scarcity of high-quality research and availability of victim services for older adults, including AIAN elders. In spite of these barriers, providers are already forced to engage in handling cases of elder mistreatment in their clinical practice.

The information obtained from this needs assessment is designed to fill a gap in practice and policy for tribal providers and perhaps lend useful insights for mainstream health providers.

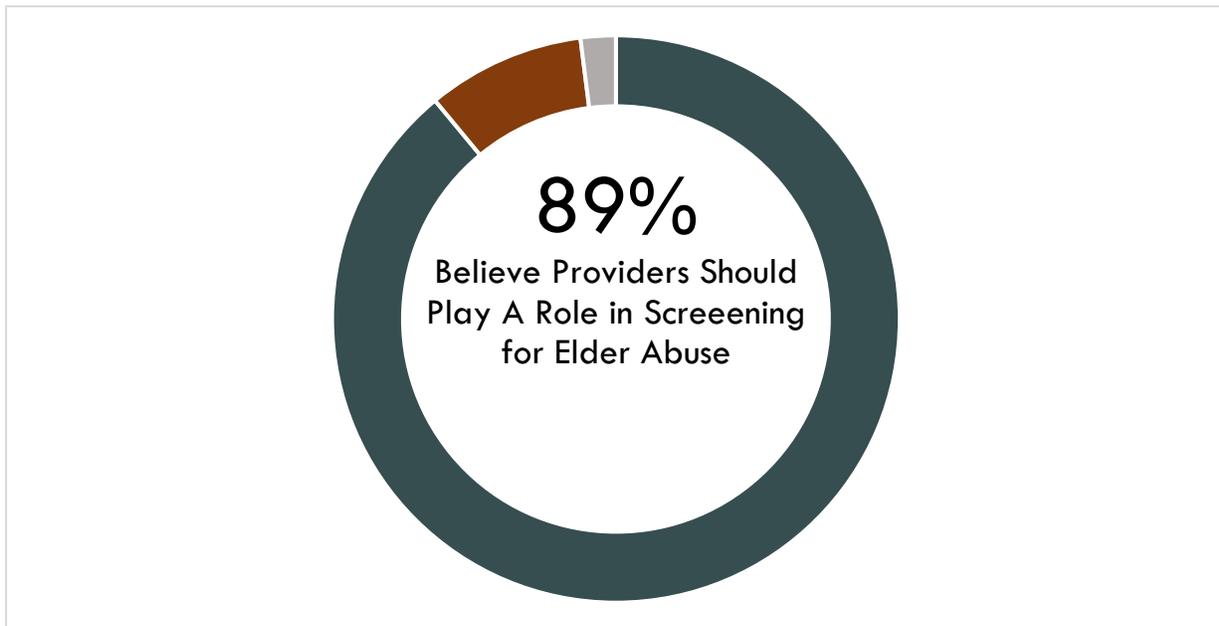
Project objectives include:

- Describe provider, community, cultural, and systematic (clinic-level) factors that contribute to how victims of elder abuse are identified and managed in outpatient clinical settings;
- Identify facilitators and barriers to recognition and management of elder abuse;
- Explore the context of providing clinical care for abused elders;
- Identify phenomena related to care of elders unique to AIAN cultures; and
- Identify existing promising practices for screening and management of elder abuse among tribal health providers.

To address the project objectives, a multi-phased mixed methods iterative design was employed, that incorporated qualitative and quantitative data collection and analysis across two data sets, including telephone interviews (n = 23) and an online survey (n=90) with participants from 22 states.

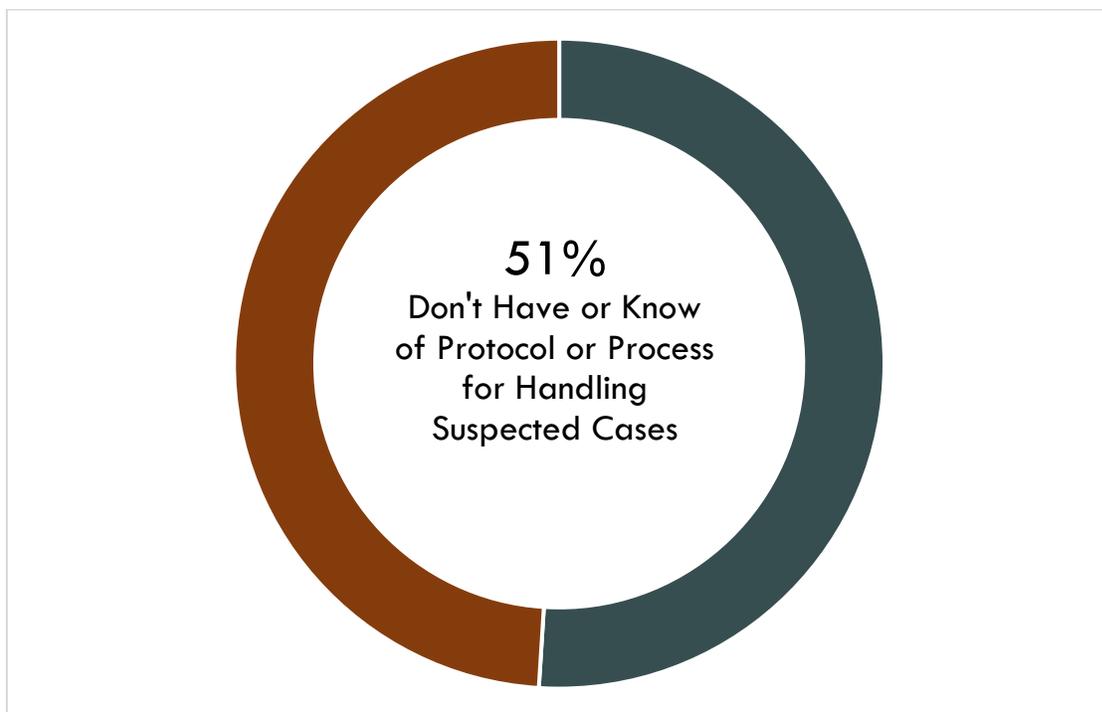
## New and Noteworthy Key Findings

- Screening is widely accepted by not widely accomplished by tribal health care providers.
  - Just 54% routinely screen for elder abuse & only three clinics use an elder specific screening tool.
  - 85% believe they have the capacity to be able to identify all different types of elder abuse.
  - Only 43% agree that they are knowledgeable about how to screen and manage for cases of elder abuse.
- Tribal health care providers are already dealing with elder abuse cases: 70% have worked with patients experiencing financial exploitation, 60% have experience with neglect or emotional abuse, and 43% have experience with physical abuse.



- Providers say they lack proper protocols for managing cases of elder abuse, have received little training, and either lack information about how to access available community services or supports, or lack the actual community services and supports to address needs.

- Essential services for Native elders face substantial deficits in funding. Provider concerns about funding deficiencies for elder services include community health, behavioral health, and access to other community and health services for elder victims of abuse including housing, food, and transportation.
- There is a need to better understand the link between culture and abuse, specifically the role of acculturation and assimilation and historical trauma at the individual, family, and community level.
- Community health representative (CHR), public health, and home health programs emerged as promising practices for both screening and as interventions in cases of alleged or confirmed abuse.



- Programs designed to reinvigorate cultural traditions such as language, culture, and food; multidisciplinary teams (MDTs); tribally funded Adult Protective Service (APS) designated workers also appeared as potential promising practices.

- Cultural programs may offer the opportunity to meaningfully engage elders and provide opportunities to reduce social isolation.
- Additional funding is needed for identified priorities including: tribal outreach and awareness (greatest need), social workers, respite and in-home nursing care, research to establish a tribal-specific evidence base for screening and interventions.

### **Policy and Practice Recommendations**

Based upon needs assessment findings and existing elder abuse literature specific to AIAN elders, the following policy and practice recommendations are offered for tribes, counties, state, and federal level policymakers as well as health care practitioners.

**Assessment findings indicate that screening tools, protocols, and training are the most pressing priorities for health care providers, though the list below is not in order of priority.**

- Development or adaptation of a tool(s) or best practices to systematically assess community supports, services, and assets for tribal health providers and elder abuse victims available within or adjacent to tribes and to tribal-serving health care entities.
- Dedicated tribal-funded APS staff person, social worker, case manager, or elder service worker(s) with APS-type roles and responsibilities (in tribes that do not currently have this type of position).
- Enhance or establish relationships between existing tribal and county APS and MDT programs and outpatient tribal health centers to promote regular opportunities for training and ongoing support of clinical staff referrals; incorporate health center staff into existing MDTs.

- Initiate or enhance tribal-run CHR and/or home health programs, or identify alternative funding streams to make current programs solvent.
- Standardized provider training on elder abuse assessment and management that addresses complicated cases, red flags, and “grey areas” that incorporates a trauma-informed care approach specific to the needs of AIAN elders
- Selection and testing of elder-specific abuse clinical screening tool including short- and long-term outcomes in tribal clinical setting.
- Testing/adaption of cultural appropriate, specific tools specific to AIAN elders
- Development of standardized screening protocols for assessing abuse and exploitation in older adults that is adaptable by local tribes and health providers for both outpatient clinic and home-based care settings.
- Training on effective use of standardized screening protocol for all health center and homebased care staff including administrative staff who have direct patient contact.
- Development of a standardized intervention protocol including suggested interventions and accompanying training that is adaptable by local tribes and health providers.
- Support for existing MDTs and expansion to new tribes for assessment, development of an action plan and systematic approach to MDTs as an elder abuse intervention with process specific evaluation or assessment to assess outcomes and identify opportunities for improvement.
- Development and empirical testing of strategies to enhance community outreach, awareness, and reporting of elder abuse including approaches to promote tribal leadership buy-in.

- Empirical assessment of the direct and indirect impact on elder abuse and exploitation of programs designed to promote cultural revitalization.

## **Conclusion**

Outpatient tribal health care provider participants are willing and ready to embrace screening for abuse among their older patients. These same providers are already required to intervene in clinical settings that more often than not lack proper protocols for managing cases of elder abuse, offer little training, and either lack information about available community services or supports or lack the actual community services and supports.

Some findings from this assessment are reflective of previous elder abuse research inclusive of AIAN communities, or support findings from research among mainstream populations, e.g., health care providers' barriers to screening. However, our project team believes the needs of tribal elders are unique, and the needs of each of the respective tribal clinics, villages, and communities is unique when it comes to addressing the issue of elder abuse. Systems, protocols, services, and supports must be designed and implemented, ideally by tribes and tribal providers themselves or in close collaboration to ensure they meet the unique needs of their tribal elders and their respective tribal clinics, villages, and communities.

## Introduction

This report describes findings from what we believe is the first and most comprehensive national needs assessments to date designed specifically to identify facilitators and barriers for screening and management of abuse by tribal health care providers among American Indian and Alaska Native (AIAN) elders. The International Association for Indigenous Aging (IA2), with funding from The National Resource Center for Reaching Victims of Crime, sought to understand the current needs and experiences of tribal health care clinics in recognizing and managing elder abuse. This assessment is part of an overarching goal of promoting and implementing screenings, referrals, and/or interventions for AIAN elders who are victims of abuse.

The project was developed based upon the belief that the diverse cultural, social, and health needs of tribal elders who are affiliated with or providers who serve the 573 federally recognized American Indian and Alaska Native Villages in the United States (U.S.) (Bureau of Indian Affairs, n.d.) creates a unique context in which to understand the recognition and management of elder abuse in outpatient clinical practice.

The objectives of the project were to:

- Describe provider, community, cultural, and systematic (clinic-level) factors that contribute to how victims of elder abuse are identified and managed in outpatient clinical settings;
- Identify facilitators and barriers to recognition and management of elder abuse;
- Explore the context of providing clinical care for abused elders;
- Identify phenomenon related to care of elders unique to AIAN cultures; and

- Identify any existing promising practices for screening and management of elder abuse among tribal health providers.

This report presents needs assessment findings with the intent of providing valuable practice and policy insights and recommendations for elder abuse screening and interventions in tribal health settings. A background of the state of the science on elder abuse from the lens of tribal elders and health care providers, the applied project methodology, findings, and a discussion that includes potential policy and practice recommendations are provided.

## **Background**

Elder abuse is a global phenomenon that takes a distressing toll on individuals, families, and communities. Estimates suggest that 1 in 6 older adults, or 15.7%, have experienced some form of abuse worldwide, with a prevalence of 11.7% in the Americas (Yon, Mikton, Gassoumis, & Wilber, 2017). However, the problem is likely more widespread, as similar to other forms of abuse, elder abuse is underreported with an estimated 1 in 24 cases reported (Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging, 2011). Though identification of a single definition is difficult (Killick, Taylor, Begley, Carter Anand, & O'Brien, 2015), the Elder Justice Roadmap, a plan supported by the U.S. Department of Justice (DOJ) and Department of Health and Human Services (HHS), defines it as:

*physical, sexual or psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity, that occurs in any setting (e.g., home, community or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability (Connolly, Brandl, & Breckman, 2014, p.3).*

According to the U.S. Centers for Disease Control and Prevention (CDC), elder abuse, mistreatment, or maltreatment can take the form of physical, emotional/psychological, sexual, financial, or neglect (Hall, Karch, & Crosby, 2016). The CDC defines the types of elder abuse as follows:

**Physical abuse:** “The intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death” (p. 31).

**Sexual abuse:** “Forced and/or unwanted sexual interaction (touching and non-touching acts) of any kind with an older adult” (p. 32).

**Emotional/psychological abuse:** “Verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress, that is perpetrated by a caregiver or other person who stands in a trust relationship to the elder” (p. 33).

**Neglect:** “Failure by a caregiver or other person in a trust relationship to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms” (p. 34).

**Financial abuse or exploitation:** “The illegal, unauthorized, or improper use of an older individual’s resources by a caregiver or other person in a trusting relationship, for the benefit of someone other than the older individual” (p. 35).

Elder abuse results in multiple negative physical and psychological outcomes. The impact ranges from visible bruises to harder to identify psychological consequences such as depression, posttraumatic stress disorder, or higher rates of later life disability (Hall et al., 2016). Victims of abuse experience mortality rates twice those of people not subjected to abuse (Baker et al., 2009). The economic impact is severe for older adults and family caregivers, not only from direct losses due to financial exploitation (MetLife Mature Market Institute, 2009), but as a result of

higher rates of hospitalization or placement in nursing homes (Rovi, Chen, Vega, Johnson, & Mouton, 2009).

Elder abuse is a problem that will compound as the population continues to age. The shifting demographic profile of older adults will include a larger percentage of people who identify as Black, Asian, AIAN, and Native Hawaiian and other Pacific Islander, while the percentage of people who identify as white will decline. The AIAN and Hawaiian and Pacific Islander populations will grow at a rate two or more times faster than whites (Ortman et al., 2014), with the AIAN population having grown 27 percent from 2000 to 2010 (Norris, Vines, & Hoeffel, 2012). AIAN elders 65 and older will more than triple, numbering 1,624,000, and those 85 years of age and older will increase more than sevenfold by 2050 (Ortman et al., 2014).

### **Abuse Research Among AIAN Elders**

The state of the science on elder abuse among AIAN people is similar to that of other minority and vulnerable groups; it is limited, progress has been slow, and solid comparable prevalence estimates are lacking (Jervis & Sconzert-Hall, 2017; Sapra et al., 2014). A recent integrative review revealed nine research articles from studies that span 30 years, with only one research article published in the past five years (Crowder, Burnett, Laughon, & Driesbach, 2019). The available research demonstrates a potentially high prevalence. For studies exclusive to AIAN elders, abuse rates of 10 to 49% have been reported (Brown, 1989; Buchwald et al., 2000). In studies that compared racial subgroups including American Indians, abuse rates were higher than whites (Baker et al., 2009; Mouton et al., 2004).

More recent subgroup analysis of the National Elder Mistreatment Study (NEMS), the largest population-based study of elder abuse prevalence in the U.S., found

that AIAN elder respondents had a cumulative prevalence almost double that of overall original study findings compared with white respondents (Crowder, Burnett, Byon, et al., 2019). The cumulative prevalence was 33% for emotional, physical, and sexual mistreatment in the past year; neglect; and financial abuse by a family member within the AIAN group. The prevalence of abuse since 60 ranged from a high of 24.7% for emotional mistreatment to a low of .6% for sexual mistreatment. Lifetime prevalence rates ranged from 34.9% for emotional mistreatment to 17.6% for sexual mistreatment (lifetime neglect and financial exploitation rates were not measured) (Crowder, Burnett, Byon, et al., 2019).

Neglect and financial exploitation are suggested in research as the most common forms of abuse experienced in Indian Country (Brown, 1989; Jervis & Sconzert-Hall, 2017; Kauffmann Associates, 2015; Maxwell & Maxwell, 1992). Potential risk factors are thought to include economic issues, substance abuse, gender (female), mental health problems, poor health, high rates of disability, single-parent households, lower education, marital status, employment status, acculturation, and caregiving-related issues (Baldrige, Nerenberg, & Benson, 2004; Brown, 1989; Buchwald et al., 2000; Jervis & Sconzert-Hall, 2017; Kauffmann Associates, 2015; Maxwell & Maxwell, 1992).

### **Native Contextual Influences on Elder Abuse**

Inter-tribal cultural diversity, tribal sovereignty, complex tribal justice systems, historical trauma, acculturation, urban migration, and demographic and health disparities are just a few issues that create the unique ecology in which abuse of AIAN elders occurs and may contribute to increased risk (Baldrige et al., 2004;

Brown, 1989; Goins et al., 2015; Jervis & Sconzert-Hall, 2017; Kauffmann Associates, 2015; Sapra et al., 2014).

Article 1, Section 8 of the Constitution dating back to 1787 codified the special government-to-government relationship between Indian tribes, considered sovereign nations, and the Federal government (“About IHS,” n.d.). As sovereign nations, federally recognized tribes have legal jurisdiction over their lands and citizens residing on those lands. Each tribe is authorized to enact its own laws, courts, and justice systems through the Indian Self-determination and Education Assistance Act and the Tribal Self-Governance Act of 1994, though not all do (U.S. Department of the Interior Indian Affairs, n.d.). Some tribes manage the response system in cases of elder abuse while others rely on adult protective service (APS) programs managed by county or state entities. Tribes who choose to manage the response to elder abuse may develop tribal codes (similar to U.S. or state-based laws) to define abuse and outline the process for reporting, investigation, or response (Baldrige et al., 2004). Jurisdiction can vary by the location of the offense, whether that land is Indian trust land or tribally controlled, whether the elder resides on or off the reservation, the race and ethnicity of the victim and perpetrator, and the nature of the crime. Tribal, state, or federal courts could maintain jurisdiction based on these factors and may be concurrent (more than one jurisdiction can hear a case), or exclusive (only one government can hear a case). Non-tribal deputies and local police may be cross-deputized to allow them to respond. Jurisdiction limits imposed on tribal courts, including the inability to prosecute non-Indian perpetrators and federal law limiting tribal courts sentencing powers, is also an issue (Baldrige et al., 2004). The resultant system can be complicated, and navigation can be a challenge for both elders, elder advocates, and law enforcement.

The AIAN elder population's demographic and health profile, is significantly different from whites and includes a higher prevalence of many known or suspected abuse risk factors. Older Indians are more likely to experience socioeconomic and health coverage disparities including lower incomes, higher rates of poverty, lower education, and higher rates of being uninsured than the general population (Goins et al., 2015). Native elders are also more likely to describe their overall health status as fair or poor, are twice as likely to be hospitalized, have higher rates of diabetes, stroke or heart attack, and reported suffering from depression more frequently than the overall U.S. population (Boccuti, Swoope, & Artiga, 2014). American Indians have also been found to experience a higher incidence of traumatic events and suffer related psychological issues over their lifetime (Çayır, Burke, Spencer, Schure, & Goins, 2018).

In addition to socioeconomic and health issues, historical trauma and loss have been suggested as possible causative factors for higher rates of violence directed at Native elders (Baldrige, 2001; Maxwell & Maxwell, 1992; Sapra et al., 2014). Early American colonization including genocide, mandatory tribal relocation practices, forcible placement of Indian children into overcrowded or abusive boarding schools, and other policies and programs designed disrupt traditional ways of tribes and challenge tribal sovereignty have only been addressed in the last few decades ("American Indian boarding schools," 2016; Garrett & Pichette, 2000). The extent and duration of ongoing emotional and psychological trauma across the lifespan encompassing generations of a massive population of people is unique to AIAN people within the application of theories of historical trauma and loss. Many are faced with near-daily reminders of these losses that are manifested in destitute conditions on some reservations, poverty in urban settings, ongoing

discrimination, and reminders of loss of culture and language (Armenta, Whitbeck, & Habecker, 2016; Whitbeck et al., 2004).

Acculturation, assimilation, or the degradation of tribal customs and norms are another frequently cited causative factors of elder abuse among American Indians and Alaska Natives (Baldrige et al., 2004; Baldrige, 2001; Hudson, Armachain, Beasley, & Carlson, 1998; Jervis & Sconzert Hall, 2017; Maxwell & Maxwell, 1992). Acculturation is the dynamic process of adapting to the mainstream culture that includes four adaptations: assimilation, integration, rejection, and deculturation (as cited in Padilla & Perez, 2003, p.37). Acculturation and assimilation (forced or otherwise) are thought to have contributed to the degradation of some tribe's sense of duty and honor to elders or resulted in a weakening of community and social structures. From federally funded boarding school programs, that forcibly removed Native children from their homes and forbid them to engage in Native customs, practices and languages, to forced assimilation through urban relocation programs in the 1950s designed ultimately to terminate government support for tribes and end protected status of lands, AIAN history is fraught with attempts at assimilation and subdue Native culture.

Boarding schools, mandatory relocation to reservations likened to concentration camps or penal colonies, forced loss of culture, policies promoting urban migration, and rampant discrimination (that persists) were among the lived experiences of many tribal elders alive today, and have created historical individual, community, and structural traumas, with intergenerational impacts (Braveheart & DeBruyn, 1998). The relationship of historical trauma and loss, acculturation or assimilation, tribal culture and norms, tribal jurisdictional or policy issues, and geographic location (urban versus rural or tribal lands) to elder abuse or other forms of interpersonal violence appear to all as yet be untested.

## **The Role of Health Care Providers in Addressing Elder Abuse**

### ***Screening is Hampered***

Nearly two decades ago Buchwald and colleagues (2000), authors of one of the few research studies of elder abuse in the AIAN population, called for health care provider training to enable screening and an appropriate response to elder mistreatment in the clinical setting. Still today, health care providers conduct very little screening for abuse or risk factors, though they have multiple opportunities to do so, and are in a unique position to screen or intervene to prevent or minimize the effects of elder abuse (Burnett, Achenbaum, & Murphy, 2014; Dong, 2015; Twomey & Weber, 2014).

In 2014, the U.S. Preventive Services Task Force (USPSTF) issued a recommendation for no general screening for elder abuse based upon insufficient evidence regarding benefits and harm from screening. Though, they did recommend routine screening of women of child-bearing age for intimate partner violence (IPV) based upon existing research (U.S. Preventive Services Task Force, 2014). The USPSTF noted that there was no direct evidence that screening for elder abuse could be harmful, though IPV literature indicated that there was the potential for small risk. Few studies supporting this assertion are available, thus the belief is largely theoretical and not based on rigorous existing evidence. Five years later, in the most recent update of the guidelines the USPSTF again found there are no existing studies assessing screening and treatment for elder abuse (Feltner et al., 2018).

Little systematic screening for elder abuse occurs. This may be the result of the USPSTF recommendations or related to a variety of barriers identified by providers. According to Dong (2015), health professionals are reluctant to address elder abuse for a variety of reasons. This might include victim denial, lack of

knowledge about reporting protocols, risk to physician patient rapport, concern over retaliation by perpetrators, time limitations, misperception that convincing evidence is necessary to report, fear of liability, lack of evidence-based interventions, and the challenge of assessing capacity in aging adults. Lack of education and training, psychological barriers on the part of providers, and reimbursement issues are additional issues providers have identified (Shefet et al., 2007). The American Medical Association and researchers and providers contributing to elder abuse literature continue to support and provide solid rationale for health care provider involvement in screening and management of elder abuse (Burnett et al., 2014; Dong, 2015; Hoover & Polson, 2014), with some suggesting that abuse should be treated by providers like any other disease (Burnett et al., 2014).

#### ***Few Evidence-Based Interventions Exist***

A consequence of chronic funding shortfalls to address elder abuse is a scarcity of high-quality research and availability of victim services geared towards older adults, including AIANs. Two published reviews of the international literature on elder abuse addressing interventions were identified; one a systematic review focused only on interventions (Ayalon, Lev, Green, & Nevo, 2016) and the second a scoping review that focused on prevention (Pillemer, Burnes, Riffin, & Lachs, 2016). Nineteen articles identified from 2000 to 2014 included interventions that targeted caregivers (institutional and unpaid/informal), three targeted older adults who were victims of abuse, and two targeted professionals responsible for preventing maltreatment. The strongest evidence base existed for interventions targeting physical restraints among paid long-term care providers, relying largely on provider education to reduce restraint use.

Pillemer et al (2016) noted only approximately 10 intervention studies had been conducted “with even minimally acceptable methods,” and most of the results were negative or ambiguous (p. S200). As a result, their selection of five promising interventions relied on multiple case studies and program description that reported positive effects, but lacked a rigorous base of evidence. The interventions identified by Pillemer et al included: caregiver interventions, money management programs, helplines, emergency shelters, and multidisciplinary teams (MDTs). The authors also note that even though “there is a paucity of evaluation data, there is consensus in the field internationally regarding the need to expand the range of services for elder mistreatment” (p. S201– S202).

A 2011 systematic review of the effectiveness of education programs designed to improve recognition and reporting of elder abuse identified just 14 articles published from 1996 to 2007 (Alt, Nguyen, & Meurer, 2011). Of these, only one program targeted practicing physicians; six programs targeted physicians-in-training; five targeted allied health professionals and aging service providers; one targeted an entire hospital staff; one targeted emergency medical service providers; two programs trained dental professionals; and one described a social work degree program with a geriatric track. Interventions generally included brief training seminars from one hour to three days. While the evidence is limited and the only existing systematic review a bit dated specific to training and educational interventions targeting health care providers, what exists indicates that among mainstream health care providers, programs for screening and management of victims of elder abuse can meet with success. Health care providers, including those in the primary care setting, are irrefutably uniquely positioned to take an active role in addressing the epidemic of abuse and violence targeting elders by addressing the issues in multiple ways. In fact, they likely already are. Though, the present literature fails to reflect these activities. Further, none of the current

literature on health care providers' intersection with elder abuse, including provider screening or interventions in the clinical setting, are specific to or incorporate AIAN elders or tribal providers. The scarcity of research and information about elder abuse in the AIAN population, complexity of the contextual and social issues they face, and lack of clinical screening and intervention studies should not deter action. The information obtained from this needs assessment, we believe, will fill a major gap in practice and policy for tribal providers and perhaps even lend useful insights for mainstream health providers.

## Methods

Answers to needs assessment questions were elicited through a multi-phased mixed methods iterative design, which incorporated qualitative and quantitative (to include demographic) data collection and analysis across two data sets including telephonic interviews and an online survey. Between January and May of 2019, a robust and comprehensive outreach effort was conducted to identify health care providers and later domestic violence advocates focused on elder abuse and tribal APS workers to participate in telephone interviews, and staff from tribal clinics to participate in the online survey. A nominal incentive identified to potential participants only as a “small gift card” was offered to interview participants and a “chance” to be entered into a drawing for survey respondents. Final incentives provided at the conclusion of data collection ranged from \$20 - \$25. Notably, almost one-third of interview participants initially offered incentives declined due to federal prohibition of the acceptance of gifts.

An email list of 281 tribal health directors were contacted. Ten percent of email addresses on that list were undeliverable. Multiple major tribal advocacy organizations and resource centers were contacted for assistance in reaching interview and survey participants, including:

- Area Indian Health Boards (11) – Variable responses
- Association of American Indian Physicians (AAIP) – Lost to follow-up
- National Center for Urban Indian Health Care (NCUIH) – Responded
- National Center on Abuse in Later Life – Unable to assist
- National Congress for American Indians (NCAI) – No response
- National Indian Council on Aging – No response
- National Indian Health Board (NIHB) – Unable to assist
- National Indigenous Elder Justice Initiative – No response
- National Resource Center for Alaska Native Elders – Lost to follow-up

- National Resource Center on Native American Aging (NRCNAA), University of North Dakota (UND) – Lost to follow-up
- Indians into Medicine Program, UND) – Responded
- Women of Color Network (WOCN) - Responded

In addition, multiple U.S. federal agencies were contacted including:

- Administration for Community Living (ACL) – Responded
- Bureau of Indian Affairs (BIA) – Responded
- Centers for Medicare and Medicaid (CMS) Tribal Technical Advisory Group (TTAG) – Responded
- Department of Justice (DOJ) – No Response
- Indian Health Service (IHS) - Responded

In total, project outreach tracking identified 366 contacts initiated for interview and survey recruitment or assistance with outreach. The total number of recipients reached via these requests is unknown as multiple tribal health directors, several Indian Health Board directors, and several IHS regional Chief Medical Officers indicated they had forwarded requests within their network of contacts.

Due to the limited response from tribal health providers for interview requests, recruitment efforts were expanded to tribal APS and domestic violence staff and elder advocates including ACL-funded Older Americans Act Title VI Directors<sup>1</sup>. A modified copy of the health provider interview guide was created for non-provider

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<sup>1</sup> Title VI programs are a part of the Older Americans Act and serve older Indians meals in congregate sites such as senior centers and provide home-delivered meals, in addition to the provision of other services both in home and in senior centers.

interviews that focused on the health care provider role, but solicited feedback from the perspective of elder service workers and advocates.

Several issues likely contributed to 1) a lack of initial response by organizations, 2) entities lost to follow-up, and 3) limited participation by health care providers. The primary issue we believe is the ongoing challenge of front-line health care providers who are overworked and under-resourced and unable to take time away from direct care. No guidance was provided by project staff regarding whether interview participants should be compensated by their clinic or organization for the time allocated for interviews or survey participation. Two providers specifically requested interviews be scheduled outside of their regular clinical hours to allow them to participate, and two additional providers were limited to scheduling interviews during their designated administrative time during the work week. Secondly, the issue of elder abuse may be potentially perceived as a lower priority than other health issues. Though, one national organization who stated they were unable to assist with distributing information about the project to their membership, indicated they did not believe the barrier to provider recruitment was perception of elder abuse as a lower priority among tribal health providers. Finally, lack of awareness or trust of the lead organization for the project among tribal health providers. Though, both organizations and individuals well known to the lead organization as well as those who had no former affiliation opted not to respond or participate. The implications of non-response by both organizations and individual providers is unknown, though it may have potentially impacted the number of providers recruited and willingness to participate.

Informed consent was not required as part of this needs assessment, though consent to record interviews was obtained from participants after an assurance of confidentiality for project participation was discussed. Following, the co-principal

investigators (co-PIs) for the project and an experienced project associate with a master's degree in social work conducted telephonic 45 minute to two-hour interviews using a semi-structured interview guide. The guide contained 46 primarily open-ended and questions with prompts and several closed-ended questions. The online survey consisted of 48 primarily close-ended questions and several open-ended questions. Where possible congruence was achieved between interview and survey question content and format. To minimize social desirability biases, participants were assured of confidentiality (for the individual, tribe, and organization) at the start of the survey and interview, and confidentiality assurances were again provided mid-way through the interview process. Personally identifiable information, tribe, or clinic names were not collected as part of the survey and were redacted from interview transcripts, with the exception of those choosing to participate in the gift card drawing who provided an email.

The assessment protocol, including project overview and copies of the interview guide and online survey, were reviewed by the national Institutional Review Board (IRB) for the U.S. Indian Health Service (IHS) and two separate tribal IRBs who determined the project did not require IRB review. **See the appendix for a copy of the tribal provider interview guide and survey.**

## **Analysis**

Assessment findings are important to consider both in the context of overall project questions and objectives (down to the individual question in some instances) and as part of the larger “big picture.” As a result, multiple methods of analysis were incorporated. This assessment used a mixed methods approach consisting of qualitative descriptive and interpretive designs for interviews, and descriptive analysis of quantitative data including frequency counts and percentages and content analysis of open-ended survey questions.

All interviews were recorded and transcribed verbatim. Dedoose was used to organize interview data, which was then analyzed and coded to indicate further areas of inquiry. The approach to thematic analysis proposed by Braun and Clarke (2006) guided the analysis process. Systematic procedures of qualitative data analysis included: initial reading of interview transcripts conducted by each PI, team development of a preliminary set of parent and child codes based on initial transcript review informed by findings from a recent integrative review of elder abuse in the AIAN population (Crowder et al, 2019), coding of one transcript by both researchers followed by discussion to validate coding methodology using first degree triangulation by researchers, intensive reading and coding of transcripts of remaining interviews conducted by co-PIs, content analysis as appropriate for interview data, and inductive thematic identification and interpretation. These processes were iterative and coding occurred concurrently from May to July for both researchers. Inconsistencies in the coding process, formulation of new parent or child codes, and differences in priority findings were resolved by the co-PIs during regular discussions. During the iterative coding process, researchers concluded that saturation was achieved when no new significant themes were elicited from subsequent coding of new transcripts compared with previous interviews. The codebook initially contained 102 parent and child codes loosely organized using the Social-Ecology of Health Model. The final codebook contained 150 parent and child codes. From this process core codes and sub-categories evolved to inductively generate emergent (axial codes) and convergent (selective) codes. Finally, to enhance methodological rigor, member checking was conducted by sharing a summary of analytic findings with interview participants for reflection and validation.

Descriptive analysis of demographic variables, organizational data, and specific interview and survey questions was conducted. The two-phase analysis of qualitative data included content and then thematic analysis. Initial content analysis of code categories identified interviews consisted of assessing and comparing code frequencies for the entire set of interview respondents followed by a comparison of code frequencies for health care providers versus non-health care providers. Data was subsequently thematically analyzed (Patton, 2002; Fereday & Muir-Cochrane, 2006) and interpreted by both co-PIs based on the identified codes. Codes and themes were confirmed by both PIs during multiple encounters to ensure credibility and increase accuracy of the analysis.

### **Sample**

Outreach efforts yielded a convenience sample that included n=24 interview participants, with one unable to attend the scheduled interview. There were n=123 initial health care provider survey respondents, with ten excluded based on a response indicating they did not serve primarily AIAN patients (50 percent or greater) in an outpatient care setting. Twenty-three respondents noted that they do serve in this setting but did not provide further responses. The final survey sample was n=90. Interview and survey respondents represented 22 different states in total. To retain a degree of anonymity, participants were not asked their tribal affiliation or clinic location.

### **Interviews**

The interview participants represent 15 different states, including two physicians that work for entities at the national level, who also have a history of local clinical experience with tribal patients. There are 13 respondents (57%) classified as health care providers and 10 classified as non-health care providers.

Health care providers include:

- 8 physicians or physician extenders (nurse practitioner or physician's assistant),
- 2 social workers,
- 1 nurse,
- 1 home health supervisor, and
- 1 behavioral health specialist.

Non-health care providers include:

- 4 APS staff,
- 3 elder services or domestic violence affiliated staff,
- 2 elder services coordinators, and one additional non-medical social worker.

A total of 52% of respondents identify their race as AIAN. The majority of health care providers (62%) do not identify as AIAN compared with the majority of non-health care providers (70%) who do identify as AIAN. The average number of years for both groups working at the current location was 11.8, ranging from 1 to 44 years. The average number of years working at the current location was slightly higher for health care providers (13.2 years +/-13.8).

The vast majority of participants in both groups work in facilities that serve primarily rural populations, the majority of the population served by both groups is AIAN only (not non-Native populations), and the majority serve multiple tribes. The majority of health care providers (69%) indicate their clinic provides primary care, behavioral health, and specialty care services. The majority (62%) of tribal health clinic staff work in clinics run by their tribe. The distribution of the percentage of patients who are sixty and older is spread across three categories (0 – 30%, 31 – 60%, and 61 – 100%), with the largest percentage of health care providers responding that 0 – 30% of their patient population is 60 and older, and the

largest percentage of elder advocates and APS workers responding that 61 – 100% of their client population is 60 and older (logically, given the focus of their role). See Table 1 for more details regarding health care provider and elder advocate interview participant responses.

**Table 1 Interview participant demographic information and details about practice location**

	Non-health care providers	Health care	Total
	n=10	n=13	n=23
Years working at current location (average)	8.9 (SD 11.0)	13.2 (SD 13.8)	11.8
Provider identifies as AIAN	7 (70.0%)	5 (38.5%)	52.2%
Types of services provided (select all that apply)			
Primary care	0 (0.0%)	9 (69.2%)	39.1%
Behavior health	2 (20.0%)	9 (69.2%)	47.8%
Specialty care/services	1 (10.0%)	9 (69.2%)	43.5%
Non-health care	7 (70.0%)	1 (7.7%)	34.8%
Information and referrals only	2 (20.0%)	1 (7.7%)	13.0%
Other	3 (30.0%)	5 (38.5%)	34.8%
Primarily Rural or urban population			
Rural	8 (80.0%)	11 (91.7%)	86.4%
Urban	1 (10.0%)	1 (8.3%)	9.1%
Suburban	0 (0.0%)	0 (0.0%)	9.1%
Multiple	1 (10.0%)	0 (0.0%)	4.5%
Clinic/practice managed by:			
Indian Health Service	5 (50.0%)	3 (23.1%)	38.1%
Tribe(s)	4 (40.0%)	8 (61.5%)	57.1%
Non-native entity	1 (10.0%)	0 (0.0%)	4.8%
Other	0 (0.0%)	2 (15.4%)	9.5%
Populations primarily served			
AIAN people only	6 (60.0%)	11 (84.6%)	73.9%
AIAN people and non-Native populations	4 (40.0%)	2 (15.4%)	26.1%
Primarily service one tribe or multiple			
One tribe	4 (40.0%)	5 (41.7%)	40.9%
Multiple	6 (60.0%)	7 (58.3%)	59.1%
Approximate % of people seen 60 years and older			

0-30%	2 (22.2%)	5 (38.5%)	31.8%
31-60%	3 (33.3%)	4 (30.8%)	31.8%
61-100%	4 (44.4%)	4 (30.8%)	36.4%

### Online Survey

The survey participants represent sixteen different states. There are 79 respondents (88%) classified as health care providers and 11 respondents (12%) classified as non-health care providers.

Health care providers include:

- 17 physicians,
- 13 nurse practitioners,
- 3 physician’s assistants, and
- 7 social workers.

39 participants provided an “other” title that was re-categorized to the following

- 4 behavioral/mental health staff,
- 6 case worker/managers,
- 3 community health staff,
- 4 health directors,
- 14 nurses, and
- 8 other medical staff.

A total of 32 respondents (36%) identify their race as AIAN. The majority of health care providers (71%) do not identify as AIAN compared with the majority of non-health care providers (82%) who do identify as AIAN. The average number of years working at the current location was 8.13, ranging from 3 months to 41 years. Most respondents are from Midwest and Western states. States with the largest number of respondents include Wisconsin (34), California (12), Washington (9), Montana (8), Oregon (6), Alaska (4), and Wyoming (4).

The majority in both groups serve primarily rural populations followed by suburban locations. Only health care providers note serving urban locations (5 respondents, 6% of health care providers). The majority of non-health care providers serve both AIAN and non-Native populations (91%) while the majority of health care providers (61%) serve AIAN patients only. The majority of both groups serve multiple tribes.

The majority of respondents work in clinics run by the IHS or the tribe itself. The majority of non-health care providers work in clinics managed by the tribe (73%) while the clinics of respondents who are health care providers is more evenly split between management by IHS (47%) and tribal management (49%). The distribution of the percentage of patients who are sixty and older is spread widely. The largest percentage of respondents indicate that 0 – 30% of their patient population is 60 years and older (41%). See Table 2 for more details regarding survey participant responses.

**Table 2 Survey participant demographic information and details about practice location**

	Non-health care providers	Health care	Total
	n=11	n=79	n=90
Years working at current location (average)	8.09 (SD 6.42)	8.13 (SD 8.38)	8.13 (SD 8.13)
Provider identifies as AIAN	9 (81.8%)	23 (29.1%)	35.56%
Types of services provided (select all that apply)			
Primary care	8 (72.7%)	58 (73.4%)	73.33%
Behavior health	6 (54.5%)	43 (54.4%)	54.44%
Specialty care/services	8 (72.7%)	36 (45.6%)	48.89%
Non-health care	9 (81.8%)	51 (64.6%)	66.67%
Other	6 (54.5%)	19 (24.1%)	27.78%
Primarily Rural or urban population			
Rural	9 (81.8%)	59 (74.7%)	75.56%
Urban	0 (0.0%)	5 (6.3%)	5.56%
Suburban	1 (9.1%)	10 (12.7%)	12.22%
Multiple	1 (9.1%)	5 (6.3%)	6.67%

Clinic/practice managed by:			
Indian Health Service	2 (18.2%)	37 (46.8%)	43.33%
Tribe(s)	8 (72.7%)	39 (49.4%)	52.22%
Non-native entity	0 (0.0%)	0 (0.0%)	0.00%
Other	1 (9.1%)	3 (3.8%)	(4.44%)
Populations primarily served			
AIAN people only	1 (9.1%)	48 (60.8%)	54.44%
AIAN people and non-Native populations	10 (90.9%)	31 (39.2%)	45.56%
Primarily service one tribe or multiple			
One tribe	3 (27.3%)	25 (31.6%)	31.11%
Multiple	8 (72.7%)	54 (68.4%)	68.89%
Approximate % of people seen 60 years and older			
0-30%	3 (27.3%)	34 (43.0%)	41.11%
31-60%	4 (36.4%)	32 (40.5%)	40.00%
61-100%	4 (36.4%)	13 (16.5%)	18.89%

## Results

The needs assessment results are based on the analysis of 23 interviews and separate analysis of findings from 90 online survey participants.

## Interview Findings

### *Thematic Analysis*

Key findings from the thematic analysis of interviews comprise the bulk of the results section. Themes are interwoven with quotes from interview participants, which allow us to tell the story in their words. A concise overview of additional findings from a content analysis of specific questions posed during interviews follows the thematic analysis.

The Social-Ecology of Health Model provides an exceptional framework for structuring results from the interview data. Variations of the ecological model have been employed in multiple elder abuse research studies. There are many formulations of the model but all have in common multilevel systems of mutual

influence and interaction, moving from the level of the individual through linkages to the larger familial, community, and societal levels. For our purposes, we have placed identified variables into the following categories: Individual, Familial, Structural, Cultural, Community, and Organizational.

### **Individual Variables**

*Theme: Elder protection of family*

**Family presence** can be a barrier to screening. Health care providers report that in the clinical setting, elders are not likely to speak of abusive situations when other family members are present. Family member presence during health care visits presents a major barrier for providers in screening for elder abuse. Many times, it is family that transports the elder to the clinical setting.

*Again, I think them not always filling out the PHQ9 form themselves, if somebody else, one of their siblings, is with them, they'll let them fill it out for them. I'm talking about extreme elders again, not a 65-year-old, but somebody in their 80s or 90s, or older. Them not filling out the forms themselves makes it difficult, some of them are very hard of hearing, so their child or spouse will answer for them, so not getting their answer makes it difficult. Time wouldn't be an issue if I could go by the PHQ9 form, and believe that that is true, I could say, "Oh, you mentioned here that people are yelling at you, can you tell me more about that" rather than me, asking the same questions, asking the sibling or spouse to leave the room, like a child, and that takes time, and then it offends everybody, which doesn't matter, "Sorry, you're offended, but we have to do this."*

*(Physician, Western Urban Clinic)*

**Reluctance to report and rights to self-determination.** Even if family are not present, health care providers share that elders are very reluctant to report family

members as abusers, and discuss elders right to refuse to report family members, and right to autonomy and self- determination.

*The problem is that almost always they'll say, "I'm okay," they'll make an excuse, "No, that's not an injury from being thrown into a wall, I fell into the couch." The problem is a lot of the time, it's the person in the room with that person. And then, immediately making a report, and trying to determine from there what kind of legal action we can set in place, but it isn't anything we can do from that point if the person denies wanting help, or wanting to report the person who is neglecting or abusing them, and that's pretty much the point where most of them fall down, the person flat out refuses to identify who it is, or to call it neglect or abuse, or to say that they were injured directly by another person.*

*(Registered Nurse, Western Primary Clinic)*

*Theme: Elder support of grandchildren*

**Grandparents putting grandchildren first.** A large number of respondents indicate that many elders are raising grandchildren and even great grandchildren, either because of substance abuse by the parents, out migration of the parents, neglect, or because financial circumstances prevent the parent from paying for care or dictate that one household must accommodate multiple generations.

*I've written note after note after note that they're just not well enough to be taking care of six grandkids, and I've had to enlarge it so they can put it on the door. I've seen a number of elders go to the grave still being expected to take care of the grandkids.*

*(Physician, Northwest Clinic)*

*It's really unfortunate. A lot of it is financial, and a lot of it is drugs and alcohol. Recently, meth has been such an insinuation, we have 160 cases of elders taking care of grandchildren because their parents have either died or been incarcerated.*

*(Adult Protective Services, Western Tribe)*

Financial abuse sometimes is the result of older grandchildren taking undue financial advantage of the elder, even residing in their home. This is true even in the presence of impoverishment of the elder.

*I think a complicating factor with the native population is a core value of caring for your children, your grandchildren, your great-grandchildren, oftentimes the line between caring and enabling is crossed, and oftentimes elders will put themselves at risk by financially supporting people with addiction, and then allowing them to live in their homes...essentially living in a flop house where they're a prisoner in their own home, which unfortunately happens pretty often, they're like, "well, I don't want them out on the streets, where they might overdose."*

*(Licensed Clinical Psychologist, Eastern Primary Care Clinic)*

## **Familial Variables**

*Theme: Honor and duty to share resources*

**Entitlement by younger generation; perceived honor and duty to share by elders.** There is overall a perceived financial dependency of youth on elders, as well as a sense of entitlement by youth. However, there is a strong culturally held

belief in one's duty and honor to share resources with family members, upholding longstanding patterns of mutual assistance.

*Homes, snow machines, cars, and money. These elders have big hearts, they offer them everything they can. That's how they were raised, and others are taking advantage of it.*

*(Elder Services Worker, Village Social Services)*

*Theme: Caregiving creates vulnerabilities for some*

**Caregiving.** Additionally, elders sometimes depend upon their children or grandchildren for care. It is at this point that the children or grandchildren may begin to take financial advantage of them. The elder may not want to report family but also does not want to lose them as caregivers, as marginal as it might be.

*The other thing is, they don't want to be left alone. They might be taking care of them, most of the time they're probably good caregivers, but there's times that they aren't, but they're thinking, "If they're not there, who's going to take care of me?"*

*(Elder Services Worker, Midwest Social Service Agency)*

**Gray areas in caregiving.** Caregiving issues were not always directly identified by participants. Often, discussion of caregiving issues arose as examples of a case of elder mistreatment. Situations they may identify as "gray areas," where it is not always a clear-cut case of abuse or exploitation, rather a question regarding the need for additional services or resources such as respite care to alleviate spousal of

family burnout home health care, homemaker services, or food and nutrition services.

*I did have a case where I almost called Adult Protective Services. I had an elderly patient with a spouse, and the elderly patient was declining and needing to be on hospice, and the spouse wanted to take care of the patient themselves, but unfortunately [the spouse] had Alzheimer's. So, the patient was not getting cared for appropriately, I contacted the daughter of the patient...The daughter, unfortunately just didn't have a really solid relationship with the spouse, who had Alzheimer's, ...and it was like pulling teeth, to be allowed to have somebody come over to the house, because the spouse was all, "I can do it, I can care," and have the heart to, there was no intention to hurt anyone. This was a couple that's been together for 40 years, the spouse just wants to care for the patient, because that's what they've always done. That was very difficult, finally the patient was sent to the nursing home, but even in the nursing home it was a continual battle with the spouse...it was a horrible situation, and from my standpoint, it was because I felt helpless. I probably should have called adult protective services, but he finally went into the nursing home, so then he was being watched and hopefully taken care of. I don't know where to put that on the spectrum because I honestly don't feel that he was being intentionally mistreated and neglected... Trying to get the family involved was hard, because they don't live in the area, calling home health to come over and they were not being welcomed into the home as you would hope, because the spouse is like, "Why can't I do it, I can care for him." You can explain it, but they don't remember it, the next day you have to explain it all over again.*

*(Physician, Western Urban Clinic)*

*Theme: Substance abuse and poverty as contributing factors*

**Substance abuse most prevalent concern.** The causal variable most cited as contributing to abusive situations, whether financial or neglectful in nature, is substance abuse by family members. Substance abuse among direct caregivers (as opposed to other family members) increases this possibility.

*One of our recent ones was this elder, she has cancer, she's really fragile, tiny, she has a home, and this guy, grandson or nephew, I don't remember the relationship exactly... He had been staying with her, and he was abusing alcohol, and the water was frozen or had stopped working, and she would make accidents in her bed and he wouldn't help her, she'd have to wait until he woke up, and she was scared of him when he'd drink.*

*(Domestic Violence Case Worker, Northern Village)*

*Substance abuse, poverty, opioid addiction is off the charts. It is making our 20-year-olds look like 50-year-olds, and making them do things against their grandmothers and grandfathers they wouldn't have ever considered doing.*

*(Adult Protective Services Worker, Southwest Tribe)*

*A lot of it has to do with substance abuse. When people are in the throes of an addiction then these traditional values we've learned about- respecting elders and holding them in high regard- completely go out the window. That's what I've seen quite a bit. A drug addict forcing an elder to go to the ATM and withdraw money for them. Or they are going to that person's apartment and pretending to have a sick child in order to secure money for whatever it is. I think that's a huge piece of this.*

*(Physician, Eastern Tribal Specialty Clinic)*

**Poverty is a factor.** Even in the absence of substance abuse, impoverishment of families overall results in crowded and substandard living conditions. In the extreme, multiple families may exist in one home. These conditions may be detrimental to the elder's well-being, contributing to neglect or financial exploitation.

*There's lack of housing and resources to implement bedbug prevention, rodents, home repairs, lack of units. So, the elder don't know how to say no, and so they've got a household of 14+ living with them.*

*(Social Worker, Northwest Primary Care Clinic)*

*I would say probably financial status – many times my experience has been mom or grandma is living in the home and somebody else is managing her income and her income is supporting the whole family. Because a large number of folks are ineligible for employment probably because of abuse, or I mean the instances of child abuse are pretty high too. So, for whatever reason they might not even be able to get a job so then they are living off that elder. And supporting the family off of that income.*

*(Social Worker, Midwest Primary Care Clinic)*

## **Structural Variables**

*Theme: Providers see patients who experience all types of abuse*

**Physical abuse easiest to identify.** Respondents indicate that the easiest type of abuse for providers to identify within the clinic setting is physical abuse. Though scenarios of providers identifying and responding to cases of emotional, physical, sexual, and financial exploitation were discussed.

*The physical is probably the easiest for providers, because that's what we're all obviously focusing on. We can see if they're becoming cathectic or malnourished, and that leads us to ask more questions, to dig a little deeper, or if there are a lot of falls going on, or if they're getting a lot of bed sores. That leads us to dig a little deeper, but with these others, you don't necessarily see it with your eyes, you're not looking at their bank account, so it's a lot harder, actually, for me, and I'd say the other providers too, that's probably the most difficult, whereas the physical is just something we see.*

*(Physician, Western Urban Clinic)*

**Financial exploitation most prevalent.** According to respondents over all the most common type of abuse is deemed to be financial, followed by emotional abuse and neglect.

*I'm gonna posit it's financial abuse because when I first started she was in a nursing home up until January or February of last year, her family pulled her out of the nursing home, they were trying to say it was because she didn't want to be there, but in fact they weren't getting her social security checks, so bringing her home ensured that they would get that financial assistance for them to be a little more solvent in their own home, and that was the thing that started that patient to be on my radar, because the public health nurses were going out there, they had discharged home health from seeing her abruptly, saying that*

*she didn't need it, with the public health services saying yes, she did need it. So, we tried to intervene, see about getting her back into a nursing home, well, it's not that easy. So public health services set it up so that the daughter would do the personal care, and the son would do everything else, getting the groceries, picking up her medication, but then that broke down pretty rapidly.*

*(Registered Nurse, Western Primary Care Clinic)*

*Theme: Difficulties with abuse assessment*

**Time and turnover key challenges for providers.** There is a consensus that there are challenges identifying abuse in the clinical setting. Most commonly discussed reasons for the difficulty include the short amount of time allotted for patient-provider interaction, provider turnover (which diminishes trust in the provider), and the presence of family members during the exam.

*...but you're handicapped because you don't know the entire social situation. You see the patient for a very short time, you don't know if that black eye is because they fell, because somebody punched them, or something else, like the dog jumped on them. You're a little bit limited because to have the info you have to have the family that the elder is usually with, and when there is no family it makes it even more difficult to ascertain the issues, there's embarrassment, there's guilt, they may not want you to know because you're not family, you're not the regular doctor that they see, because he's on vacation. Medicine is very fragmented, nowadays, it's hard to see the same person twice.*

*(Physician, East Coast)*

*...with the turnover rate that we have, training each individual to discern the types of abuse is really hard, because it's really common in a rural community, the turnover rate of our nurses and doctors, it's not consistent, let's say a doctor starts seeing one of the elders, they don't know them enough, or they don't see them enough, to be able to see if something is going on. I think it's really hard to even identify the elder abuse, because the elder doesn't talk about it right away, especially if it's their first time seeing them.*

*(Domestic Violence Worker, Village Social Services)*

**Damaging relationships.** Some providers are concerned that reporting alleged cases of abuse may result in patients discontinuing care or it may disrupt the provider relationship. Though there is the more prominent belief that elder safety is paramount and the right response can allay concerns.

*Caretaker was a little upset, but it didn't impact the relationship actually. The way it was expressed to him at the time, we are just worried about your mom and make sure she was okay. The kind of messaging to the son was, part of it was the caretaker had some insight into his own use and abuse of substance use and in a sense recognized that we were putting him on notice. But that was, so, he may not have liked it, but that's part of the dimension of doing this work in tribal communities. There is more of an expectation the community is going to be looking after folks and keeping an eye on folks.*

*(Tribal Adult Protective Services, Northeast)*

*Reports rarely seem to result in patients no longer seeking out health care services.*

*Do you ever have elders who stop coming to the clinic or using services or do they always end up coming back?*

*They'll stop for a little while but they come back. Or they'll say I don't want anybody coming into my home and they'll call in a couple weeks and want somebody to deliver their meds or want somebody to come out and sweep or mop their floors. It happens. They'll kick us out or they'll stop coming but they come back.*

*(Social Worker, Midwest Primary Care Clinic)*

*Theme: Few standardized protocols*

**Screening and standardized protocols lacking.** Most respondents indicate their clinic uses a standard IPV screening tool often accompanied by a mental health screening tool. Findings indicate that standardized protocols, to include elder abuse specific screening, are lacking.

*There really isn't a protocol. It's pretty much individual to whatever staff person there is who gets that person. One person might be more willing to refer than another person.*

*(Tribal Adult Protective Services, Northeast)*

Only one provider currently uses an elder abuse screening tool, which has met with success.

*It started early last year with Dr. \_\_\_\_'s team....and we've started looking at ways that we can formalize training, We started using the Elder Abuse Suspicion Index. It's a 6-question screening that was used for primary care, the provider basically assesses for broad abuse and mistreatment. We tested it last*

*year, screening everyone in Dr. \_\_\_\_'s clinic, 55 and up, and last week we rolled it out to all the teams, currently now everyone that comes to the clinic is supposed to be screened, at least annually, for elder abuse.*

*(Licensed Clinical Psychologist, Eastern Primary Care Clinic)*

Lack of standardized screening or protocols is sometimes a function of funding issues within the health care organization (see below under Organizational Variables). Various tribal systems sometimes establish their own protocols or are working on development of protocols.

*That's something that I'm working on, getting some protocols in place, written down, "when we get a call, this is what we do." When I first came on the job, there was nothing, and everything I had to learn by myself, and I just want to get everything in place, I want to get policies and procedures, protocols, everything in place, I don't want anybody to be stuck in that place like when I first came. If I don't know how to do something, I Google it, and that's how I learn stuff. I also have a very good relationship with \_\_\_\_ services, it's not a Native American agency, everyone's white, but they are so helpful, they've been so helpful to me since I've been there. They have different subjects, they have different people coming in and presenting, and I've gotten guidance from some of those members, and it's just been a big help to me.*

*(Tribal Adult Protective Services, Midwest)*

*Theme: Providers can and should play a role*

**Providers can be successful and should be engaged.** Even in the face of multiple challenges, with one exception, both health care providers and non-health care providers believe that providers can be successful and should be engaged in identifying and managing elder abuse.

*I think we should play the—I don't want to say primary role, but that first screening, that first stage, we're the ones who can actually pick up on it when no one else can. Even as simple as, we are able to touch and pull up the sleeve, and check the blood pressure and listen to the heart and lungs, so we see things that other people aren't going to see, even without having to necessarily ask, and so by seeing that, it will prompt you to ask.... I think that we're kind of that first line of defense, honestly.*

*(Physician, Western Urban Health Clinic)*

**Importance of building trust.** Another issue is the importance of establishing trust and rapport with patients to encourage them to share concerns or respond honestly to screening tools, which is difficult given high provider turnover rates.

*Having enough of a rapport with a senior or the elder or an adult to want to talk about it. For them to admit or cop to any real concerns. You are going through a list of questions just reading them off and it's easy for them to say, "nope, nope, nope." Whereas, if you kind of talk to them and have a warm engagement with them, they might be willing to talk and just finish the checklist with you.*

*(Adult Protective Services, Southwest Tribe)*

## **Cultural Variables**

*Respect for elders as a function of culture*

**Strengths: Respect, family first, community, pride, resiliency.** Respect for elders is present within most communities and a strength of Native culture, but comments indicate that the respect traditionally shown to elders has decreased among the younger generation and virtually dissolves in the face of substance abuse. The assumption of elder respect due to the elder being “Indian” is not necessarily true “anymore.”

*Now that the younger generation is here, it's sad to say... no. They're not revered, there are younger adults that... I don't know how to explain it, but elders aren't respected the way they once were. The younger generation is a lot more careless, they don't see the elders as important, I think.*

*(Elder Services Worker, Village Social Services)*

Other strengths include putting family first, strong community connections, pride and resiliency.

*Their strengths are the same as the weaknesses. They are family. They live as family units. They frequent each other a lot, as far as visiting. They are pretty solid family units. Which is also the weakness. They are afraid to tell anybody or anybody in the law enforcement, they are family too. They eat dinner together, it's definitely a strength. And they help each other out in quite a lot of ways. The Individualized ones where it is just one or two that are disconnected, that's where the trouble is. In the larger families with 2 or 3 or 4 different households, they take care of each other. It's like the Samoan they moved here together, they take care of each other, they take care of themselves, they all*

*share, and they all eat like kings It's pretty much the case here, but it's a little different financially Not all the Native families came as a whole. So, the separated ones have trouble.*

*(Elder Services Advocate, Village Social Services)*

*Pride. Their protective factor of their families. Even though it can delay my work I still see that as a strength. They are protective of their families. They will go to the ends of the world for their families these elders will. With the little they receive they really take care of themselves and their families. Sharing resources.*

*(Tribal Adult Protective Services 2, Midwest)*

**Strengths do not always provide protection.** Respondents caution that you cannot assume elders are not abused because of community strengths and indicate that culture does not always ensure protection.

*Very respected but again I say that then I look at the instances of abuse and exploitation and things we have and I struggle with saying that.*

*(Social Worker, Midwest Primary Care Clinic)*

*Theme: Role of acculturation is unclear*

**Acculturation increases the likelihood for abuse.** Respondents were asked to indicate whether they thought that acculturation into mainstream life increases the possibility of abuse. Some respondents believe acculturation does indeed increase the possibility of abuse; this includes the majority of non-health care providers.

*Yes absolutely. If you were to rate it from 1 to 10 it'd be 9 and . as being the major contributing factor.*

*(Elder Services Advocate, Northwest Tribe)*

*Yeah, I do. It makes it more likely. If they are truly traditional and have that strong belief, we don't ever get calls to their house. It could be they just don't call us, but at the same time I feel like that strong belief that elders are to be treasured is very strong with traditional belief system. As you get more into the mainstream, obviously there are people who believe they are still to be treasured but you start getting into drugs and alcohol. It's not uncommon for grandkids to take advantage of grandparents, that kind of thing.*

*(Tribal Adult Protective Services, Northeast)*

Maybe, or maybe not. However, this belief is not consistent across all interviews; particularly among health care providers.

*No. I don't see it, other than—that, in itself, no, but the clash [between generations], yes.*

*(Physician's Assistant, Western Urban Indian Clinic)*

*That's kind of a difficult thing to make assumptions about. I think a lot of times being connected to your community and your cultural identity can be a strength and a resilience but I don't know if it's strong enough to stop someone from participating or being affected by abuse. I think that's a tricky thing to make assumptions about.*

*(Physician, Eastern Tribal Specialty Clinic)*

*Boy you know I don't think it has an effect either way. I really don't. Because I see both sides of it. I see the family where there was never a history of abuse or neglect or anything and now it's happening. I see the flipside of that where it has been a life cycle.*

*(Social Worker, Midwest Primary Health Clinic)*

*Theme: Abuse discouraged as community /familial topic*

**“We don't talk about that.”** There was a sense that elder abuse not overtly talked about, coupled with “looking the other way” to protect the community and the family as part of cultural values.

*.... family values of helping versus enabling, and then at the same time the kind of traditional values where you don't talk about your people, you don't talk about that stuff, not just elder abuse but sexual abuse, drug abuse, I think discussing that is an ongoing struggle.*

*(Licensed Clinical Psychologist, Eastern Primary Care Clinic)*

*Theme: Historical trauma*

**Forced assimilation, racism, cycle of violence, boarding schools, and providers as symbols of white authority plague tribal communities.** The presence of

historical trauma is thought to increase the probability of abuse, and have a connection to the incidence and prevalence of substance abuse in tribal communities.

*I had this opportunity to listen to a tribal elder who told me that she went out with her family, she has ancestors that are buried in a special place at Lake Tahoe, on one of the beaches, so she went to pay her respects with her family, to her ancestors, and because it was very close to a summer cabin, the people who were renting this summer cabin came out, and looked at her and her family and said, "What are you doing here?" And instead of saying, "We're here to respect our elders, this is their cemetery," they left. And I said, "You're kidding me, why wouldn't you stand up to them, and say that these are our tribal ancestors?" And she looked at me and she said, "Because we would rather not engage with those people," -- and boy, that was just said with pure and utter hatred-- "we decided to leave." And that just gave me this microcosm of how they think, they don't go to the lake even though that was their summer gathering ground, because they hate interacting with people who treat them like that. They don't even want to go there, they don't want to even have that interaction because it reminds them of what they've lost, what their cultures and ancestors have been through. It gave me this phenomenal insight into their thinking. The hatred of the white person is so totally justified, how would you like to be there? For a day, I was just devastated by that, thinking through what they go through, all the time, even down here they go through that stuff. They go through people even like in the emergency room that despise them, I'm like, "Are you kidding me?" I'm blown away, so how they deal with this stuff is truly amazing to me, that they find the courage to come to this clinic, that they do try, as hard as they can, in their own way, to get help.*

*(Registered Nurse, Western Primary Care Clinic)*

*Oh, it's huge, I've seen a lot of that. Mental health and trauma, the combination. I've seen it lived in families right left and here and there. A lot of communities are worse than others. The folks who come in for help, to seek housing or whatever, just... The one trauma tool we use the ACEs [Adverse Childhood Experiences] survey, they say if there is 4 indicators or more there is going to be issues and they are mental health issues. Better than 50% of our survey respondents come in with 4 or more. The mental health, the things it does to the mind over time is just... I've been around it enough that I'm just happy that I think I've kept my mind pretty clean and straight. But it's... they're... Their minds are abused. More than physically. Or mental health is a side effect of social factors that has taken the brunt of it over the years....The employment, the drinking, the abuse. The folks that are being abused and the folks that are doing it. It probably it isn't their fault. Their parents and when they were children ...anybody that does stuff like that has a mental problem, but the cause of it. The why, why, why getting to the root of the problem.*

*(Domestic Violence Worker, Village Social Services)*

Life under forced colonization and structural violence is one of emotional and cultural trauma. These intergenerational traumatic memories continue to affect the physical and emotional health of populations who have suffered abuse on multiple levels.

*They've been here for a long time, they know the situation that is at hand, they experienced the historical trauma on tribal lands, reservations, and that historical trauma is real. A lot of people don't understand historical trauma, but*

*you just have to spend some time on reservations to get a feel for how people take it out on each other. It's a component of elder abuse.*

*(Physician, East Coast)*

*Elders of any native tribe, mine included, I feel like elders are vessels of cultural renewal, they hold the stories of creation for the tribe, and the tribe I work for now, they are trying to reinvigorate their language, and for me, for the Navajo side, I've heard my language spoken, but my mother, she was beaten at the boarding school, for speaking her language, as you talk about this ingrained abusive type of experience that the natives have had, it's institutionalized. And so, the tribe we have now, we had an Indian school, not too far from here, in which children were actually, they lost their lives, and the parents didn't know for months. And so, on a more serene note, the tribes themselves, they want the elders to come forward with the knowledge.*

*(Physician, Western Primary Care Clinic)*

*Theme: Cultural renewal as possible intervention*

**“Culture as prevention.”** Tribal efforts at cultural renewal are seen as a potential pathway to indirectly (or directly) address elder abuse.

*I deal with several tribes and those tribes with strong language programs and cultural programs don't have high elder abuse because they still respect their elders, because children know what respect is, and children are happy to hold grandmas' hand or attend a ball game. Linguistic or historical connection tribes*

*should have. I see that on other reservations and other communities. I've seen tribes where culture is endangered and they have high incidence of elder abuse.*

*(Elder Services Advocate, Northwest Tribe)*

*There are so many strengths from what I see, cultural tradition being one of them. With our agency serving over 120 tribes, that means we have many different spiritual protocols, ceremonies, you name it, so many different cultural things. A huge thing that we implement here, because we see it as a strength of our community, is culture as prevention. So that's why they often go to sweat ceremonies, we also have sage and we smudge clients as needed, we have connections with local spiritual healers, and so cultural identity is such a huge strength here, and we really try to promote that and I think sometimes it can be maybe some pressure for maybe some staff maybe who don't identify as native, but also educating our staff can connect the individual, the client, with the cultural resources that they need, so when you ask me about strength, that's definitely the primary one there, the cultural components, and that's really why I think we're one of the longest lasting urban Indian health organizations in \_\_\_\_\_, because there have been others but they've closed down, and we've been the primary agency to continue our services and stay open, because we continue to provide those cultural services because it's been an identified need by our community members throughout the many community needs assessments that we've completed, so that's the community strength for sure.*

*(Licensed Clinical Social Worker, Western Urban Indian Health Center)*

## **Community Variables**

*Theme: Lack of priority*

Low priority and underreported. Many feel that elder abuse is not a priority in their tribal community.

*I can't speak to that. What I understand is, our social service person focuses her energies on the young, the children, which is extremely noble. Those situations break my heart. But that leaves, definitely a problem with access to resources for elders or anybody else that might need social services help. We do have TANF and there are all types of other programs on paper that are supposed to help, CMS Native health, native this that and other but I don't see us being able to access those resources. When I make a report, typically the thing is the thing I get back is that they don't have any resources for this person. I just get the feeling that there is an expectation that social services are supposed to address everyone's social service issues and needs, but if there is only one social services person, how is that supposed happen?*

*(Registered Nurse, Western Primary Care Clinic)*

*Each year when we have our elections for council members, it's always like, "respect your elders," but to be honest, I don't see it. Like when the government shutdown happened, the first programs that were cut were elderly nutrition and my program, and commodities. And these are essential services for the elders, I was floored by that. Our leadership themselves didn't think twice about cutting these programs, and I think that says a lot.*

*(Tribal Adult Protective Services 2, Midwest)*

Overall, abuse is thought to be under-reported. The result of both individual, familial, cultural and community values and beliefs.

*It still remains underreported. We do a survey for our title VI funding every 3 years it's a survey that includes those same topics. Even on our survey we do to get our funding, what we see most of the time is they'll answer the cigarette, alcohol, substance abuse like that but they won't do the answers on elder abuse. We can't force them to do it. Even though we know there is suspected abuse or there is credible evidence we can't answer the questionnaire. I think it's underreported because of intimidation or the love factor.*

*(Elder Services Advocate, Northwest Tribe)*

*Theme: Promising interventions*

**Home health has a unique perspective and is a valuable tool.** Surveillance by community health workers (CHRs), community health personnel, and home health programs is very instrumental in both the identification of, and intervention in, abusive situations.

*I would say any of the employee's outpatient health care providers that are doing home visits or seeing clients in the home regularly probably have a better, they've got their finger on the pulse of what is going on so they have a better idea of the risk for a senior right away. Emotional abuse, living in unsanitary conditions. I think a lot of the outpatient providers who are going into the homes provide a lot of the referrals we get. We work very closely with them to wrap our client or elder in services through our services or any other at the tribe they may need to utilize. They are aware, talking to seniors if not daily than*

*weekly. Helping with meds they sometimes get to see how the family interacts or what challenges that particular individual is having in their home.*

*(Tribal Adult Protective Services, Southwest)*

*When we are suspecting abuse and neglect possibly happening in a home that hasn't been substantiated, you know we've reported it but the elder won't substantiate it, we are increasing services. Maybe sending a homecare worker in twice a week or sending that community health representative in once maybe on Mondays to do blood pressures and on Wednesdays to do read their blood sugar monitors. We'll find reasons to get staff into those homes a little bit more, if we can. That for even if they are finding things in the clinic that the docs are letting us know, hey I think something is going on, can you guys get some staff out there a little bit more.*

*(Social Worker, Midwest Primary Care Clinic)*

Home health staff are a respected part of the community.

*I think they're in the home more, they're more engaged in the community. Need to have to report based on what they see. I also feel like, caring for that family they just feel like they need to do this. A lot of them share with the elders. I have to report this. I have concerns for you. After I've gone in to do an investigation, they'll be like, "oh yeah I believe it was the community health nurse." It's okay and they start talking.*

*(Tribal Adult Protective Services 2, Midwest)*

**Home health programs at risk.** However, public health programs are endangered or have already been eliminated in some areas.

*Yeah, home health is going away, and I think that is going to be a big loss, because we're not going to have the in-house monitoring. I think home health is more than just whatever education they're doing, it's actually having people in the house to see what the environment is like.*

*(Physician's Assistant, Western Urban Indian Health Clinic)*

**Multidisciplinary teams are thought to be effective.** The presence of more or dedicated elder abuse funding is associated with protocol/screening and the existence of tribal multidisciplinary teams (MDTs) or formal approaches to cross-agency collaboration to address elder mistreatment. MDTs are seen as very effective in communities that use them.

*Last year I started a task force which consists of our diabetes, nurses, housing, incentives, low-income housing, heating programs, a protection worker, our medical social worker, our case manager... we kind of go over a lot of these cases, and we do referrals. Every quarter we meet with the dialysis center and let them know which individuals are new dialysis patients, we make sure we're all versed, who hasn't been going to their sessions. The hospitals have been great. Every year we actually go up there and do an introduction of our services and we've gone up to the hospitals several times to do cultural awareness presentations, like if they're doing a prayer, what sweetgrass is, so people aren't like, "they mistreated me because I'm native."*

*(Tribal Adult Protective Services, Midwest)*

**Community outreach and education high priority.** In our research, non-medical community members at times would make “drop-in” visits to those elders they felt were at risk. Elder abuse reports are often the result of anonymous reports by community members. For this reason, there is a strong consensus that one of the priority needs is community awareness (and community surveillance) about elder abuse.

*Raising awareness, and my coworker, she did a flyer, she sent it to the radio station, so they actually announce it, and they just talk about elder abuse. It just says, “Elderly Protection services, elder abuse, taking care of one elder at a time.” Since she did that, we have been getting more calls, I think. I think raising the awareness, would really make a difference. Just letting elders know they don’t have to live like that, if they’re not taken care of, or not feeling safe, you don’t have to live like that.*

*(Tribal Adult Protective Services, Midwest)*

This should include helping elders and families understand the need for healthy boundaries and understanding what abuse is and is not.

*You know, I think educating those victims that what they are living with is not okay. You know just because it’s your daughter and you don’t want to get her in trouble. Just cause it’s your grandson and you love him. You still don’t deserve to be treated like that. I think that that’s the biggest roadblock we hit out here. Is letting that elder know that you deserve to be treated with dignity and love and respect and not taken advantage of and abused.*

*(Social Worker, Midwest Primary Care Clinic)*

### **Organizational Variables**

*Theme: Positive interactions with referral agencies essential, room for improvement*

**APS and law enforcement important allies.** Respondents indicate that working with APS is for the most part a positive experience, though this varies from one tribe to the next. Interactions with law enforcement are likewise perceived largely in a positive way though communication is at times an issue in some tribes.

*A positive example would be, I had a patient not too long ago who presented with some kind of depressive symptoms, and I went in and talked to her, and it was the same kind of situation we talked about, she had family members living with her, there was drug abuse, financially taking advantage of her, and she didn't really know what to do about it. There was some violence, shoving, threats of violence, and so we reported to Protective Services, and they ended up showing up and she ended up being removed from her home, and so I think that pretty much worked pretty well.*

*(Licensed Clinical Psychologist, Eastern Primary Care Clinic).*

Several respondents discussed the perception that APS is busy, overwhelmed, or has very high caseloads.

*What I understand is, our social service person focuses her energies on the young, the children, which is extremely noble. Those situations break my heart. But that leaves, definitely a problem with access to resources for elders or anybody else that might need social services help. We do have TANF and there*

*are all types of other programs on paper that are supposed to help, CMS Native health, native this that and other but I don't see us being able to access those resources. When I make a report, typically the thing is the thing I get back is that they don't have any resources for this person. I just get the feeling that there is an expectation that social services are supposed to address everyone's social service issues and needs, but if there is only one social services person, how is that supposed happen?*

*(Registered Nurse, Western Primary Care Clinic)*

**Feedback and reporting an issue; tribally run APS may have better outcomes.**

However, feedback after reporting and intervention is sometimes lacking or it is perceived that nothing is ever done. When the APS and law enforcement organizations are tribally run (versus county or state), results are more beneficial.

*Before we had our own tribal safety family program, before that we had to contact counties for that assistance and we had to submit a report or whatever and so when that was happening the communication was even worse. When we submitted an APS referral, we never heard anything back. It was always up to us to reach out and get an update on what was happening. And they'd say 'oh it's an open case' or 'it's an open investigation' and we would be like can you actually tell us where you are at in the process or should we change anything about when this person comes in? Is it only supposed to be a certain person bringing them in? And they never provided any helpful information about that. I felt like none of those were handled well. They were not communicating well with us about the progress in that case, timeline or any of those sorts of things.*

*(Physician, Eastern Specialty Clinic)*

*Theme: Jurisdictional issues a challenge*

**Jurisdictional issues a major barrier.** However, jurisdictional issues or conflicts in protocols between agencies are cited frequently. Many may be due to the overlapping geographic areas served by the health care system. Sometimes one clinic might serve several different states. For example, there are “border” communities with various confusing and conflicting jurisdictional issues. In other cases, tribal lands encompass multiple counties and require coordination with different APS or law enforcement agencies.

*It's hard. We have \_\_\_ and tribal [APS]. What's accepted by us is totally different than what the county will. For other counties it has to be extreme before they get involved. For better or worse we do a lot of preventive services. Part of that's because we have a low case load, so they expect us to do more and to accept more. It's hard when a county doesn't accept something we would have accepted. A lot of times we will at least do an intake and see if we can help resolve, like if it's one phone call or something.*

*(Tribal Adult Protective Services, Northeast)*

## **Needs**

*Theme: Funding underscores multiple needs*

According to respondents, the most frequent need is outreach and awareness (see previous section). There is also an expressed over-arching need for more funding for all elder services.

*Funding. More funding. For community events, incentives to get people to come out, or sit at the table to talk. Making everything, every engagement a warm place where they feel safe enough to talk and that may be an event, or food, or a meal that feeds and nurtures them in some way. More money for resources, for things we can use, technology in the community. Like research or assessment tools*

*(Tribal Adult Protective Services, Southwest)*

*I wish there was like elder abuse grants, it would be nice if there was more, if there was something specific to elders. We get federal funding, but not for elders, we get elder funding from the state.*

*(Domestic Violence Director, Midwest)*

*...we haven't had psychiatry in over a decade, and we've got some need in that area, and there are some tribal health people that have been working really hard to get that reinstated. We just don't have really good resources in that. We tend to cover those things only after the bad stuff has happened. Prevention is not realized to be the more cost-effective way of doing things, things have to go haywire before we address them.*

*(Physician, Northwest Primary Care Clinic)*

**More needs.** Almost all respondents express a need for additional social workers, additional training in screening and intervention, and a standardized protocol for

screening and intervention. In addition, there are needs for other services to be added such as respite care, in-home nursing care, food, safety inspections, transportation, and temporary housing for at risk elders.

*As well as resources available to our case manager, we need the ability of the elders to be fed, we need the ability for them to have a center, we need a place for them to go where family members can have a respite.*

*(Physician, Western Primary Care Clinic)*

These needs are all expressed in the context of the need for a multidisciplinary or holistic response at assessing and meeting elder's needs in order to prevent or address elder abuse and exploitation.

### **Content Analysis**

Table 3 includes frequencies and percentages for several categorical questions asked as part of interviews.

- 84.6% of health care providers agree/strongly agree that outpatient health care providers are capable of identifying all different types of elder abuse; 55.5% of non health care providers agree/strongly agree that health care providers are capable
- 69.2% of health care providers feel they have adequate training in elder abuse screening and management; 33.3% of non-health care providers feel they have adequate training
- 76.9% of health care providers would like to receive additional training; 88.9% of non-health care providers would like to receive additional training

- 58.3% of health care providers say their state requires mandatory reporting of elder abuse; 70% of non-health care providers indicate this is the case
- 54.5% of health care providers say their tribe requires mandatory reporting; 66.7% of nonhealth care providers indicate this is the case
- 69.2% of health care providers say their clinic has a screening process in place for elder mistreatment or domestic violence; 60% of non-health care providers are unsure if the clinic has screening in place
- While many health care providers say they have screening tools in place for domestic violence, IPV, and/or mental health screenings that are non-elder specific used with elders, one clinic has implemented an elder specific tool.
- Only a few health care providers indicate they have a clear protocol in place for handling instances of alleged elder abuse.
- 58.2% of health care providers believe acculturation has no relationship or don't know if it has no relationship to elder abuse; 80% of non-health care providers believe acculturation increases the risk for elder abuse
- 69.2% of health care providers have made a referral to APS for suspected cases of elder abuse
- 38.5% of health care providers have made a referral to law enforcement
- 38.5% of health care providers have made a referral to another entity
- The quality of relationships and communication with outside entities varies between tribal communities. For APS providers and law enforcement equal numbers of respondents identify issues with either entity, as said they are also an important resource or good ally.
- Referrals to APS are the second most frequent intervention employed by health care providers.
- Interventions for elder abuse listed in order of frequency include:

- Employing additional resources such as nursing care, respite care, food, home repairs or shelter
- Reporting to APS
- MDTs or formal community cross-collaboration to address cases of abuse
- Community health representatives and home health as prevention or intervention in cases of suspected or confirmed abuse
- Availability of additional office staff to make and manage referrals for services
- Outplacement of elders from their homes, primarily to nursing homes as most shelters can't accommodate needs of elders
- Reporting to law enforcement
- Safety planning
- Referral to behavioral health
- Building trust and rapport to facilitate reporting of abuse by clients
- Facilitating identification of power of attorney or guardianship

**Table 3 Interview Participant Responses on Elder Abuse and Mistreatment Experiences**

	<b>Non-health care providers</b>	<b>Health care</b>	<b>Total</b>
	n=10	n=13	n=23
Outpatient providers are capable of identifying all different types of elder abuse			
Strongly disagree	0 (0.0%)	0 (0.0%)	0.0%
Disagree	2 (22.2%)	1 (7.7%)	13.6%
Neutral	2 (22.2%)	1 (7.7%)	13.6%
Agree	4 (44.4%)	8 (61.5%)	54.5%
Strongly agree	1 (11.1%)	3 (23.1%)	18.2%

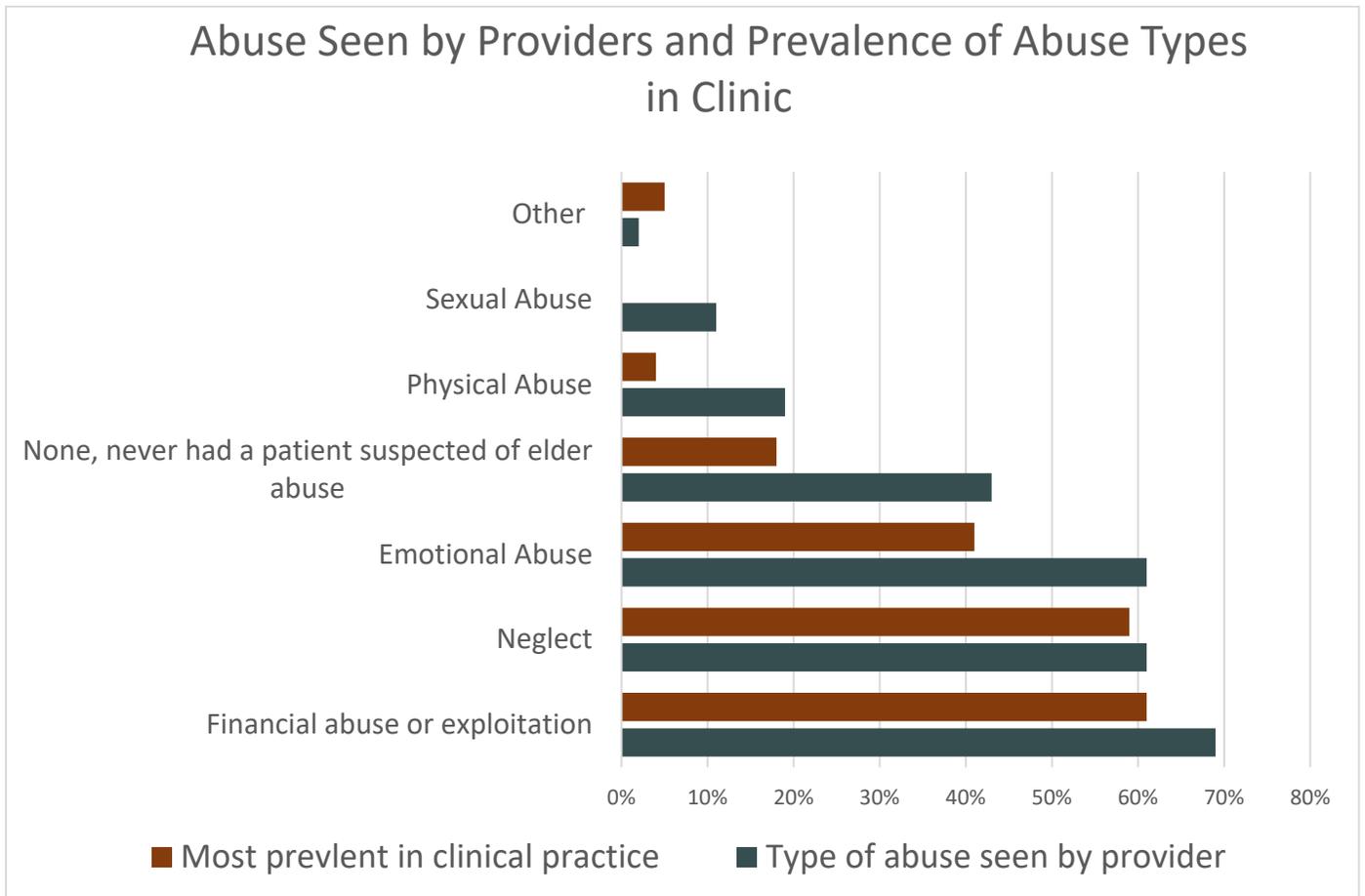
Have adequate training in elder mistreatment, detection, management, and reporting	3 (33.3%)	9 (69.2%)	54.5%
Would like to receive training in elder mistreatment, detection, management and reporting	8 (88.9%)	10 (76.9%)	81.8%
State requires mandatory reporting of suspected cases of elder abuse			
Yes	7 (70.0%)	7 (58.3%)	63.6%
No	1 (10.0%)	5 (41.7%)	27.3%
I don't know	2 (20.0%)	0 (0.0%)	9.1%
Tribe requires mandatory reporting			
Yes	6 (66.7%)	6 (54.5%)	60.0%
No	3 (33.3%)	5 (45.5%)	40.0%
Clinic has a screening process for elder mistreatment or domestic violence	1 (9.1%)	48 (60.8%)	54.44%
Yes	3 (30.0%)	9 (69.2%)	52.2%
No	1 (10.0%)	4 (30.8%)	21.7%
I don't know	1 (10.0%)	4 (30.8%)	21.7%
Does acculturation make a person/family more or less likely to experience abuse?			
Less Likely	0 (0.0%)	0 (0.0%)	0.0%
More Likely	8 (80.0%)	5 (41.7%)	59.1%
No Relationship	0 (0.0%)	4 (33.3%)	18.2%
I don't know	2 (20.0%)	3 (25.0%)	22.7%
Made referral to APS	-	9 (69.2%)	69.2%
Made referral to law enforcement	-	5 (38.5%)	38.5%
Made a referral to another entity	-	5 (38.5%)	38.5%

### Survey Findings

As noted, results reflect feedback from 90 survey respondents that work in clinics serving primarily AIAN patients. Respondents were asked a series of questions regarding their own experience and the clinic's experience with elder abuse including either closed-ended (categorical) or open-ended

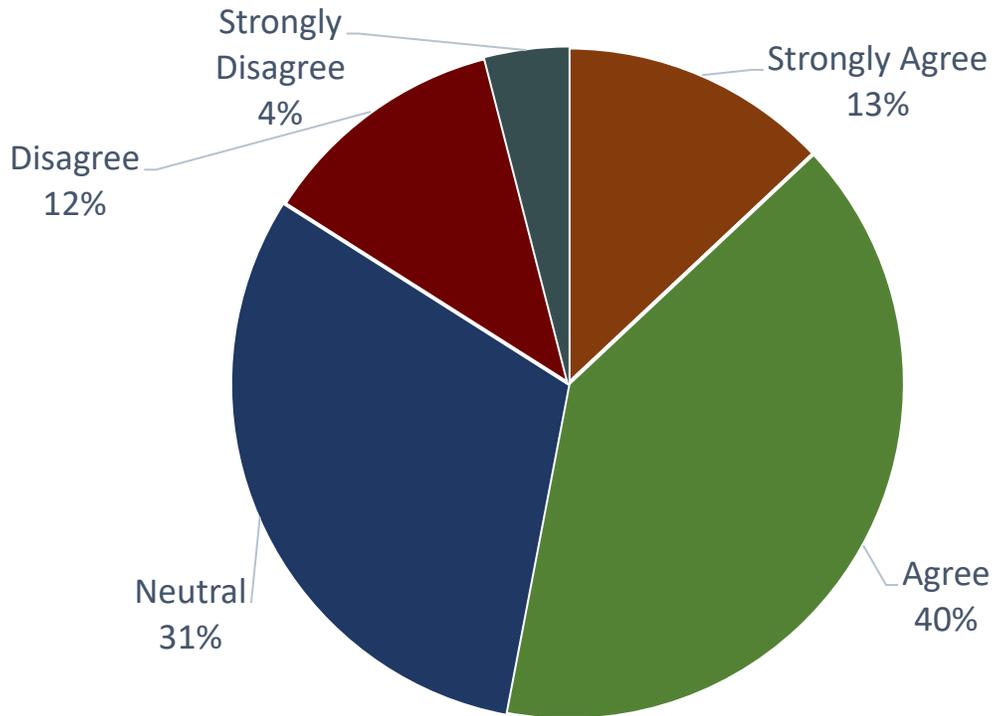
response options. Multiple questions asked providers to respond to a Likert-scale with scales for instance, ranging from strongly disagree (1), neutral (3) to strongly agree (5).

The type of abuse respondents experience most frequently is financial abuse or exploitation (69%) followed by emotional abuse and neglect (61%). While health care providers note financial abuse or exploitation as the highest (70%) form of abuse seen, non-health care providers cite emotional abuse (67%). Financial abuse or exploitation is the most prevalent in clinical practice (61%).

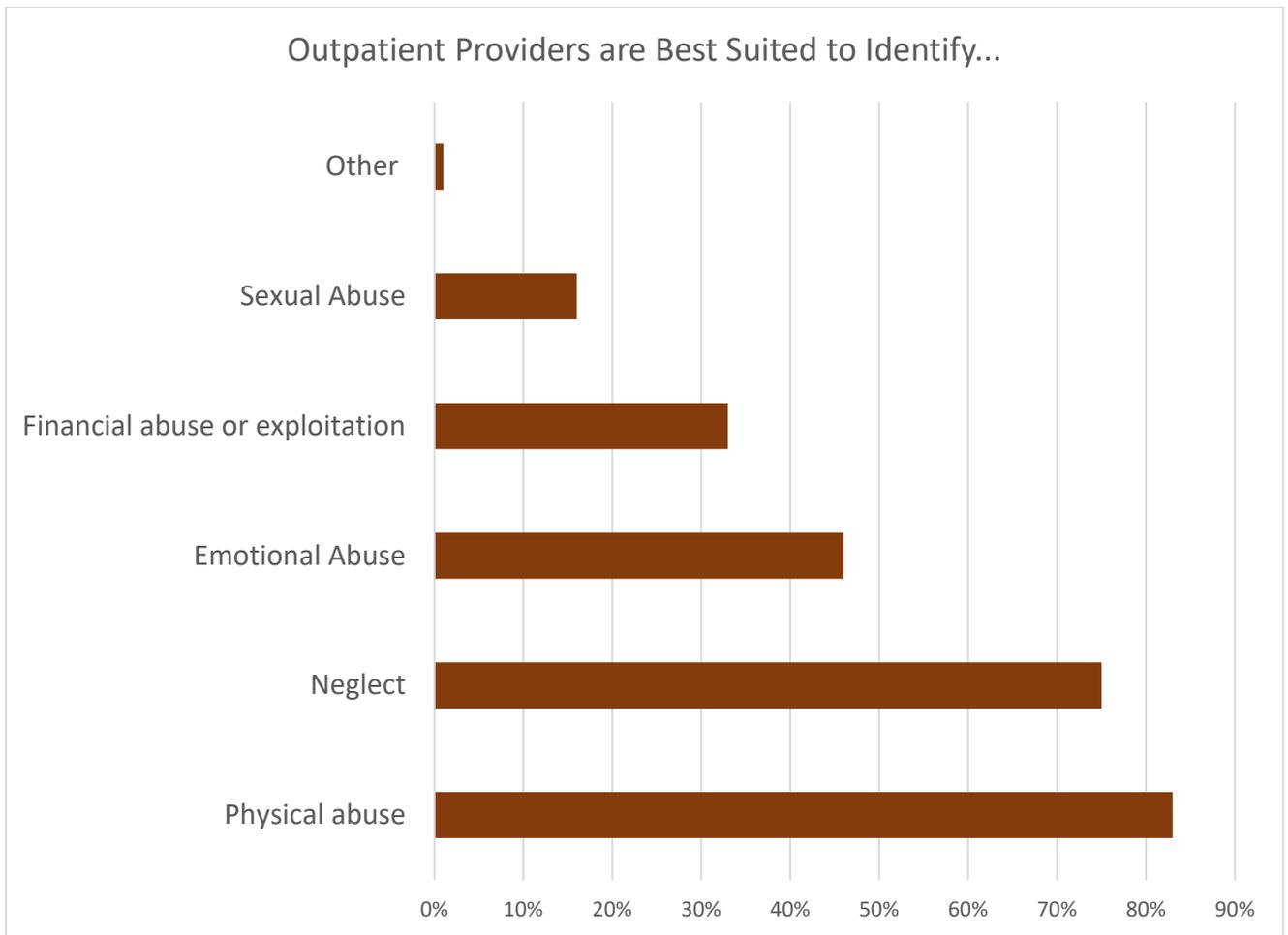


The majority of both health care providers and non-health care providers (53%) agree or strongly agree that outpatient providers are capable of identifying all types of elder abuse.

### Outpatient Providers Are Capable of Identifying All Different Types of Elder Abuse



Of the major types of abuse, respondents believe that providers are better suited to identify physical abuse (83%) and neglect (75%). A minority note that providers are best suited to identify sexual abuse.



After identifying a case of potential elder abuse, slightly less than half (49%) have referred a case to another agency outside the clinic per protocol. Half of health care providers have made an outside referral and 44% of non-health care providers have referred outside the clinic.

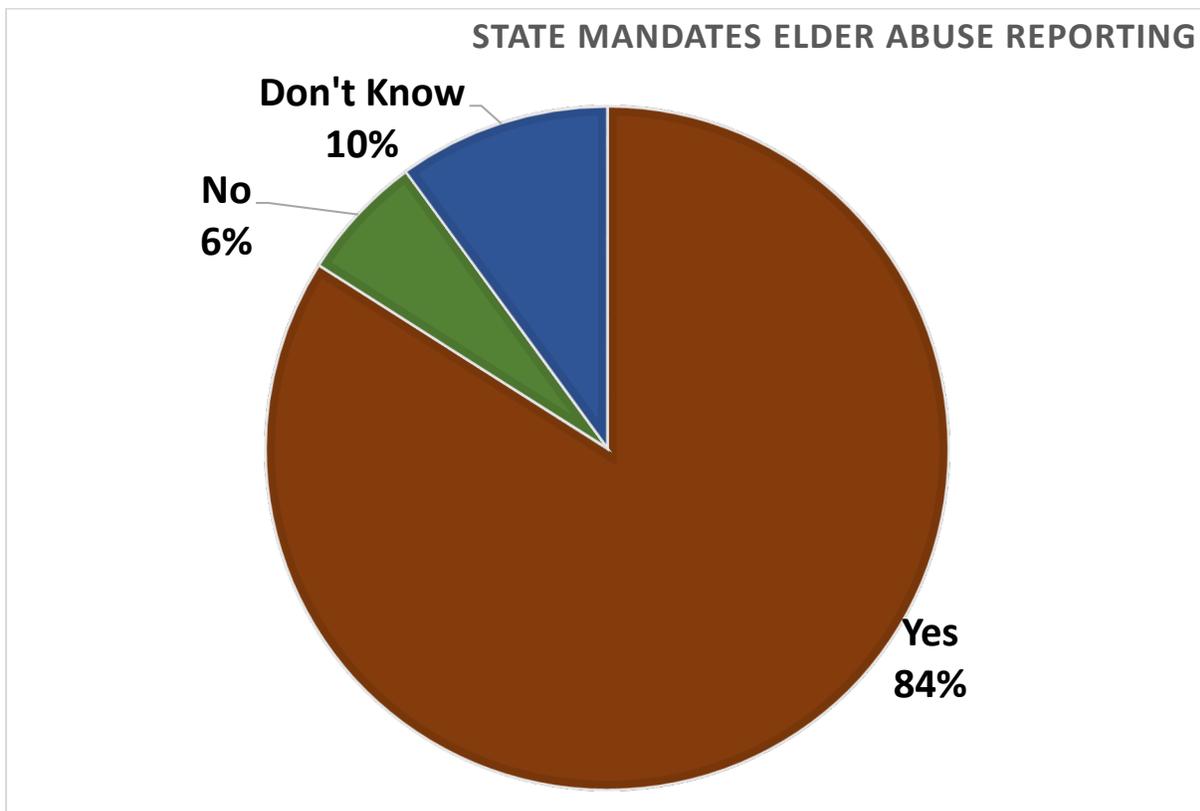
Of those who rated the handling of past cases by other entities, slightly more felt the case was handled poorly or very poorly (42%) compared to well or very well (40%).

Top responses for why a case was not handled well by an outside agency include:

- no follow-up (5),
- inappropriate follow through with elder (4),

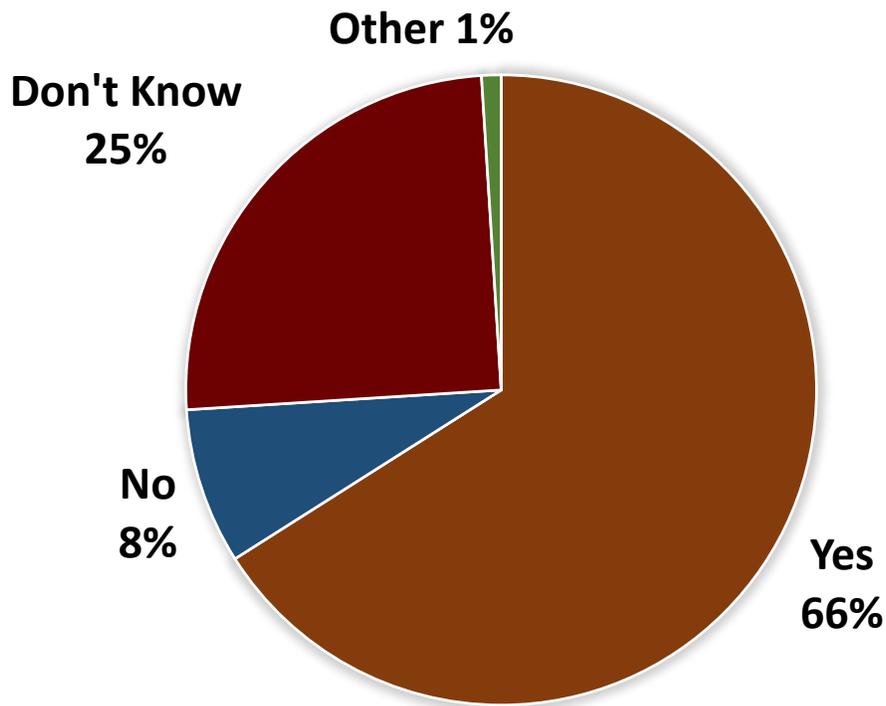
- the elder was not eligible for the outside agency (3),
- cases took a long time to resolve (2), and
- cultural factors such as distrust, cultural awareness, and attendance to native elders, provided barriers (2).

The feeling that a case was handled well was the top view of why providers felt an outside agency addressed the situation well. Other views address specific components of outside agencies’.



The majority of responders note that both their state and tribe mandate reporting of elder abuse. Tribes are less likely to mandate reporting.

**TRIBE MANDATES ELDER ABUSE REPORTING**



When commenting on mandatory reporting most note it is positive. Barriers to mandatory reporting include lack of awareness, lack of enforcement, and difficulty when an elder denies apparent abuse.

In addition to reporting, respondents commented on screening in tribal clinic settings. The majority (54%) do not routinely screen for elder abuse. This statement is true for both health care providers (54%) and non-health care providers (56%). When describing screening, of 29 respondents, 18 use informal screening tools while 7 identify formalized tools.

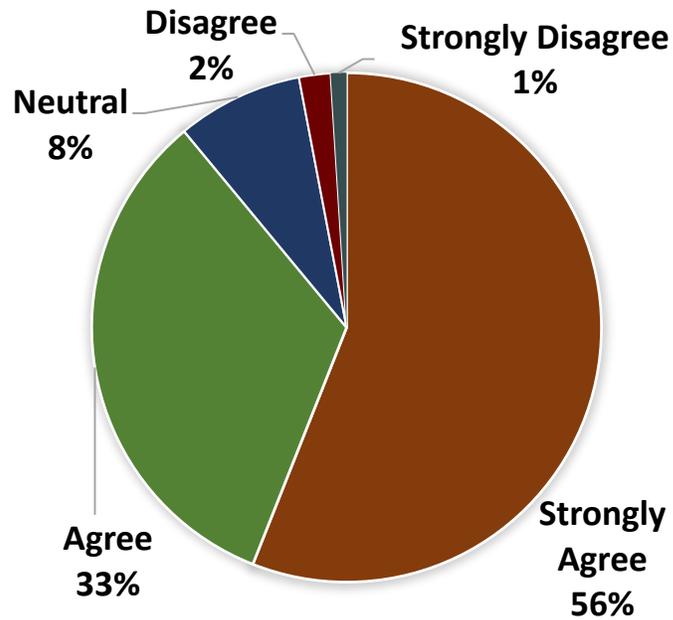
Formal Screening Tools	Informal Screening Methods
Domestic violence screening tool (unspecified)	Asking the patient

Elder Abuse, Neglect and Family Violence: A Guide for Health Care Professionals	Home visit assessment
GPRA	Internal tool
PHQ-9 (Depression)	Patient History
Promis-29	Physical Exam
PPMS	Questionnaire
Vulnerability to Abuse Screening Scale (VASS)	

On standard protocols and processes for handling suspected cases of elder abuse, approximately half of respondents' clinics have protocols (49%) and half do not have a protocol or are not aware of a protocol (24% no protocol, 27% do not know of protocol). The majority of respondents note some form of reporting or referral process including to APS, tribal police, social services, or other agencies. Other protocols include documentation requirements and training.

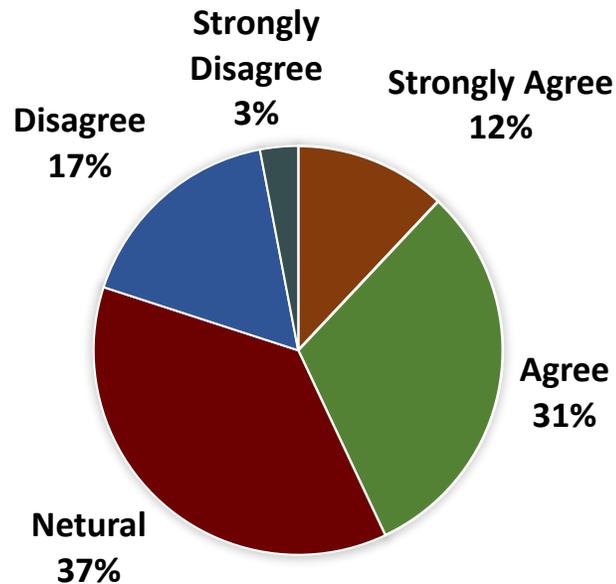
On the role of providers, the 89% of respondents agree or strongly agree that providers in outpatient settings should play a role in screening for elder mistreatment.

**ALL CLINICAL PROVIDERS IN OUTPATIENT CARE  
SETTINGS SHOULD PLAY A ROLE IN SCREENING FOR  
ELDER ABUSE AND MISTREATMENT**



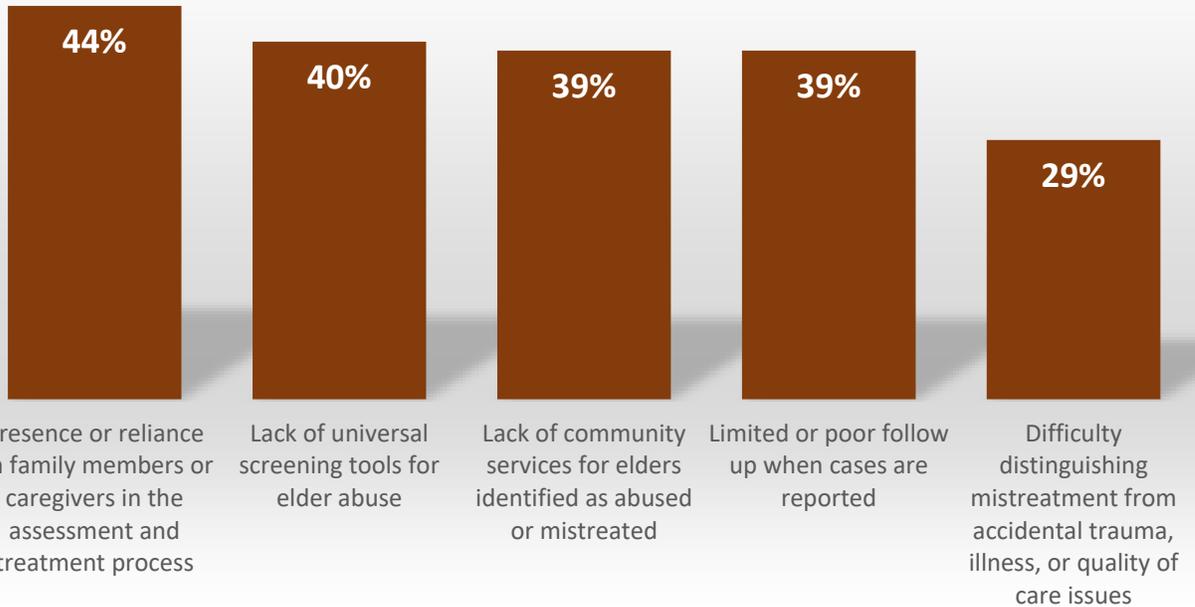
When asked to assess their own abilities, a minority of respondents strongly agree or agree (43%) that they are knowledgeable.

**I CONSIDER MYSELF TO BE KNOWLEDGEABLE ABOUT  
BEST PRACTICES FOR IDENTIFYING CASES OF SUSPECTED  
ELDER MISTREATMENT**

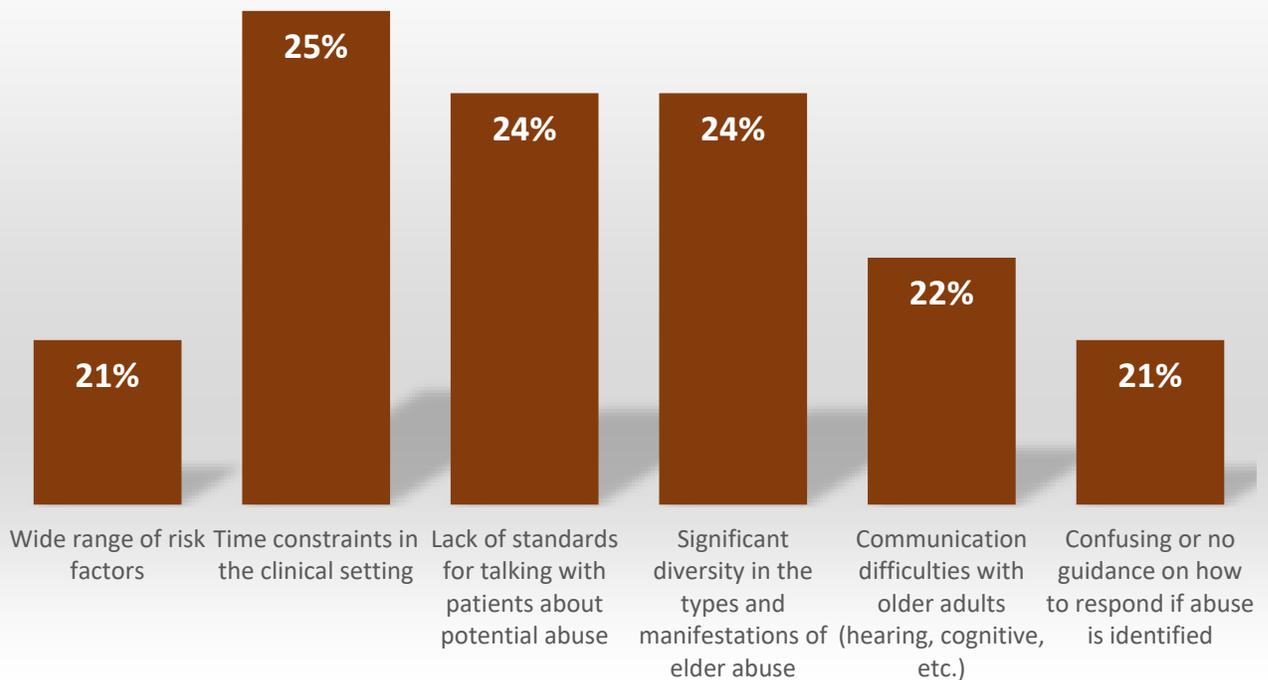


The top barriers to screening selected from a pre-identified list are the presence of family and caregivers at the appointment, and larger community or agency barriers such as lack of screening tools and lack of services. Additional barriers offered are cultural awareness, trust, and not wanting to report family members who are perpetrators.

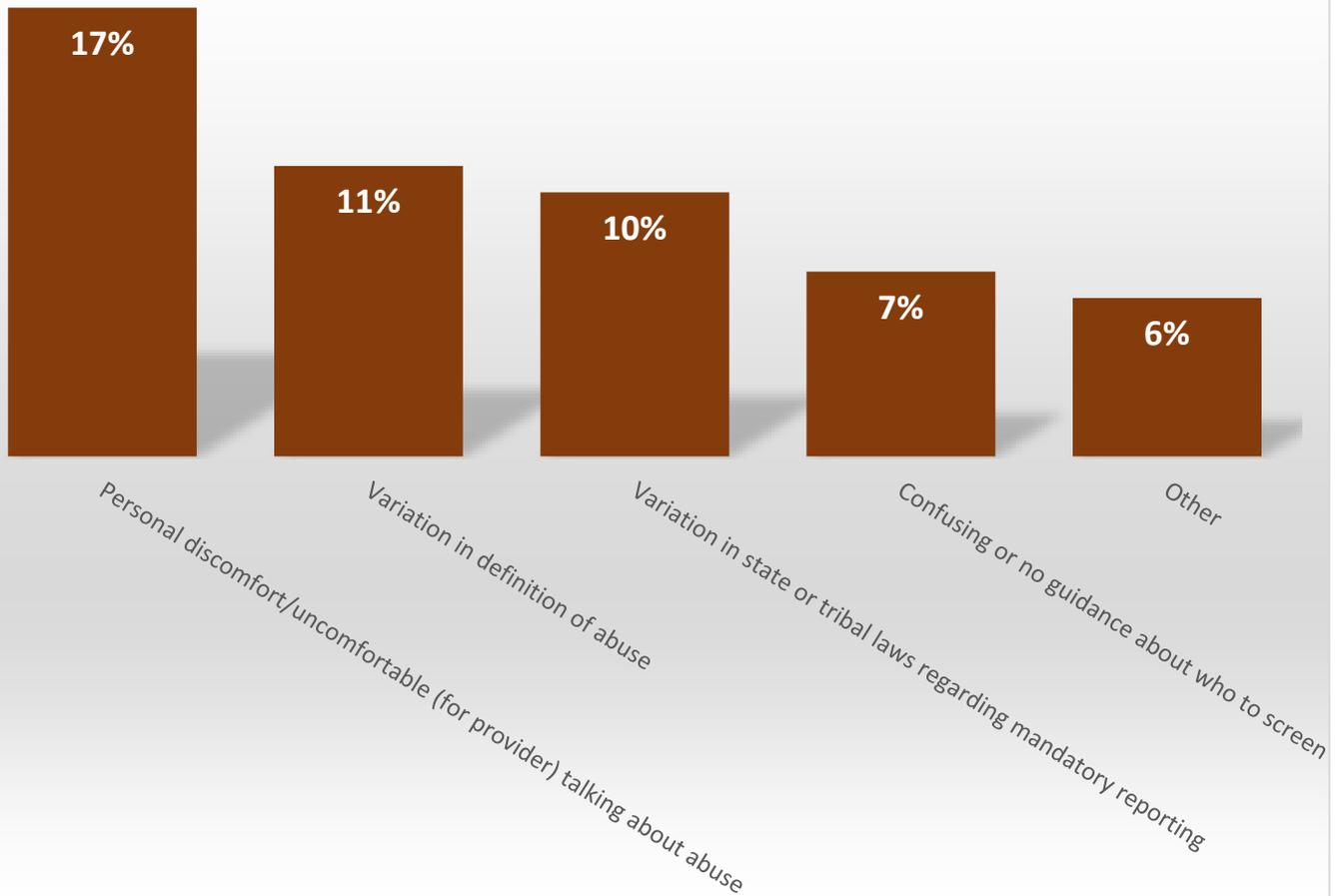
## Barriers to Elder Abuse Screening



## Barriers to Elder Abuse Screening (Continued)



## Barriers to Elder Abuse Screening (Continued)

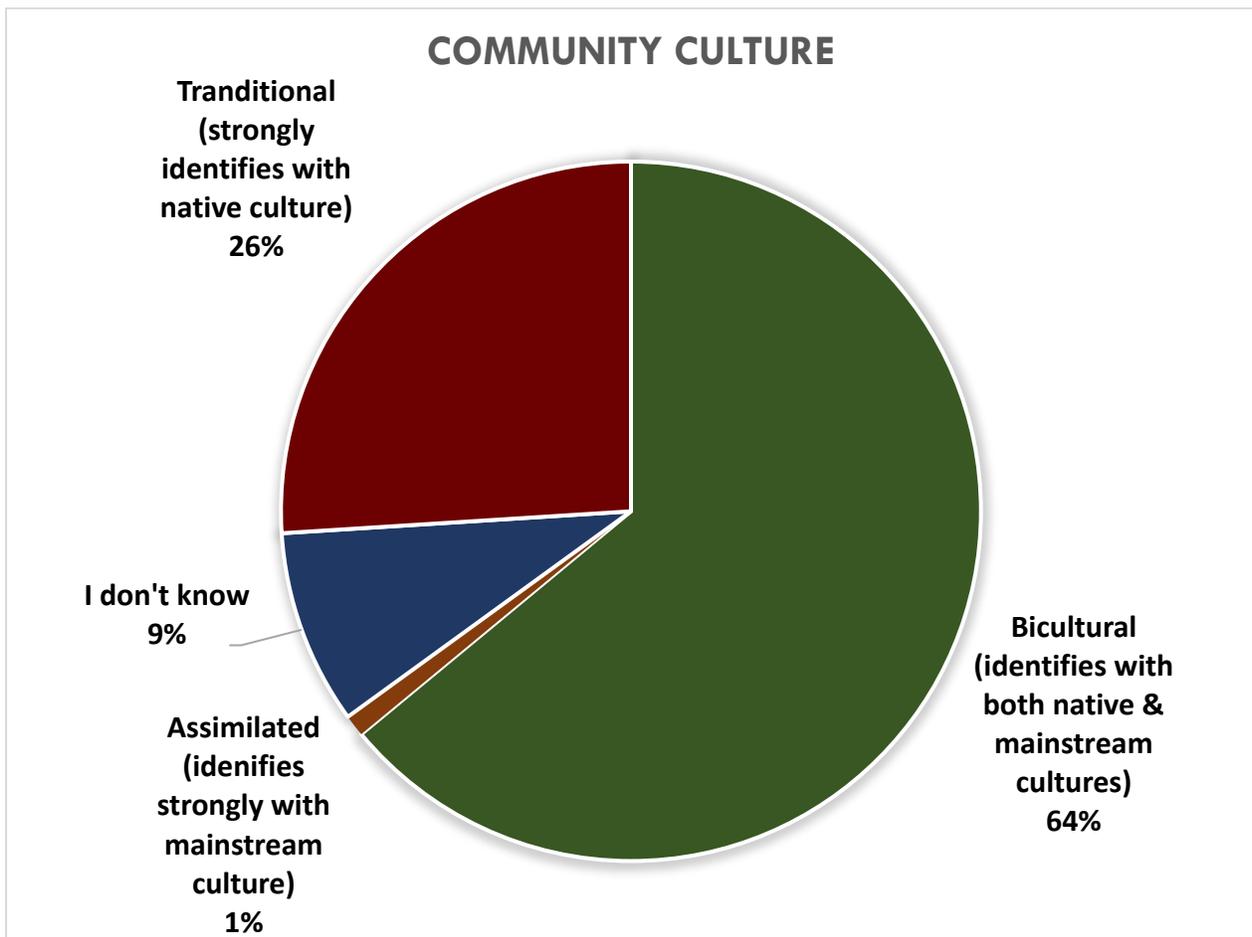


Respondents were also surveyed on a series of questions around needed resources, best practices, and trainings. When asked in an open-ended format what resources, tools, or information are needed to improve screening the predominant answer is protocol implementation followed by training, screening tools, and resources.

Few respondents are able to cite specific examples of clinics employing best practices. In training, both health care and non-health care providers feel they do not have adequate training in elder abuse detection, management, and reporting (69%) and the majority express interest in more training (79%). A wide variety of

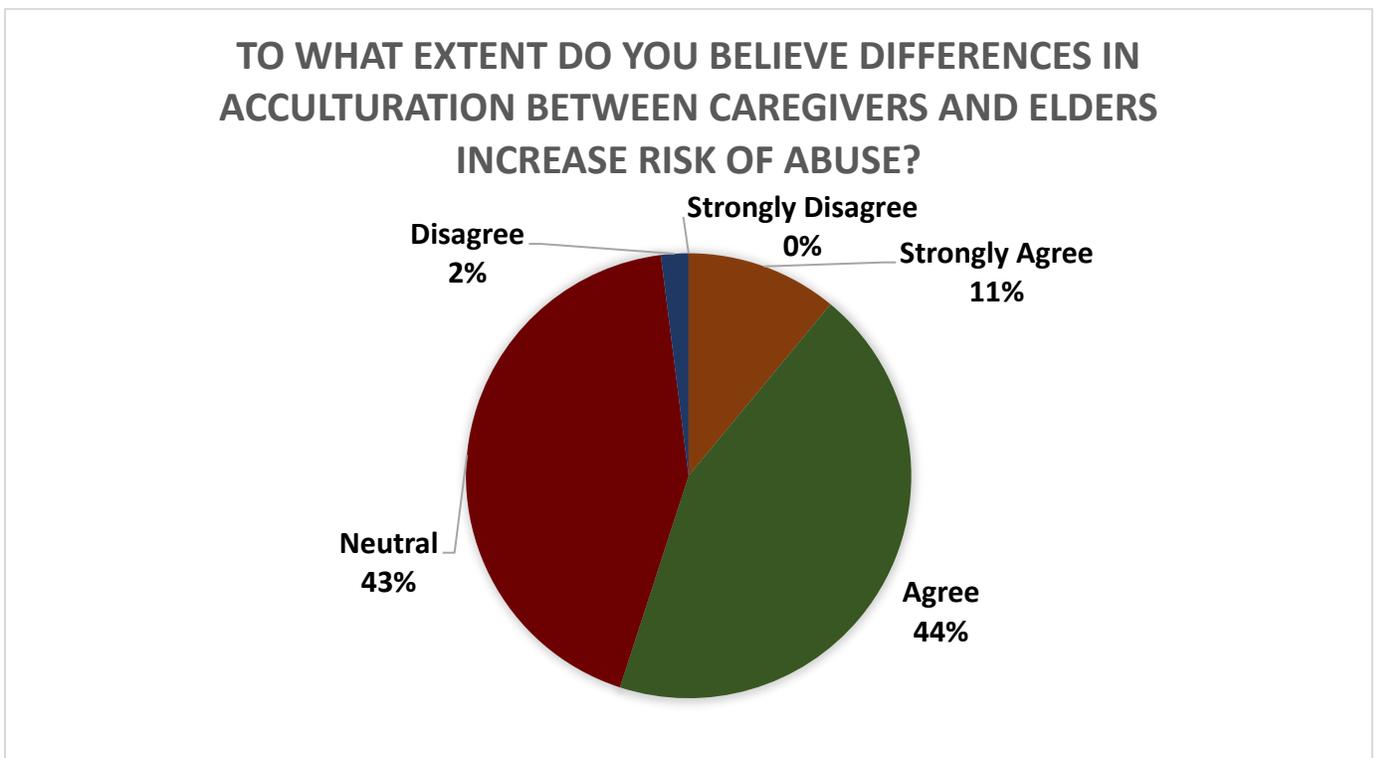
training topics were suggested. The top suggestions are training on screening, identification of abuse, resources for victims, protocols for abuse cases, and how to work with victims.

To further the inquiry into the experience of Indian Country specifically, providers were asked about the level of traditionalism or assimilation of the community served by their clinic. Only one provider notes that the community is assimilated (or strongly identified with the mainstream). The majority of providers identify their community as bicultural (64%) and 26% note their community is traditional (strongly identifying with native cultures).



More respondents agree or strongly agree that acculturation has an effect on the prevalence of elder abuse (50%) compared to those that agree or strongly agree

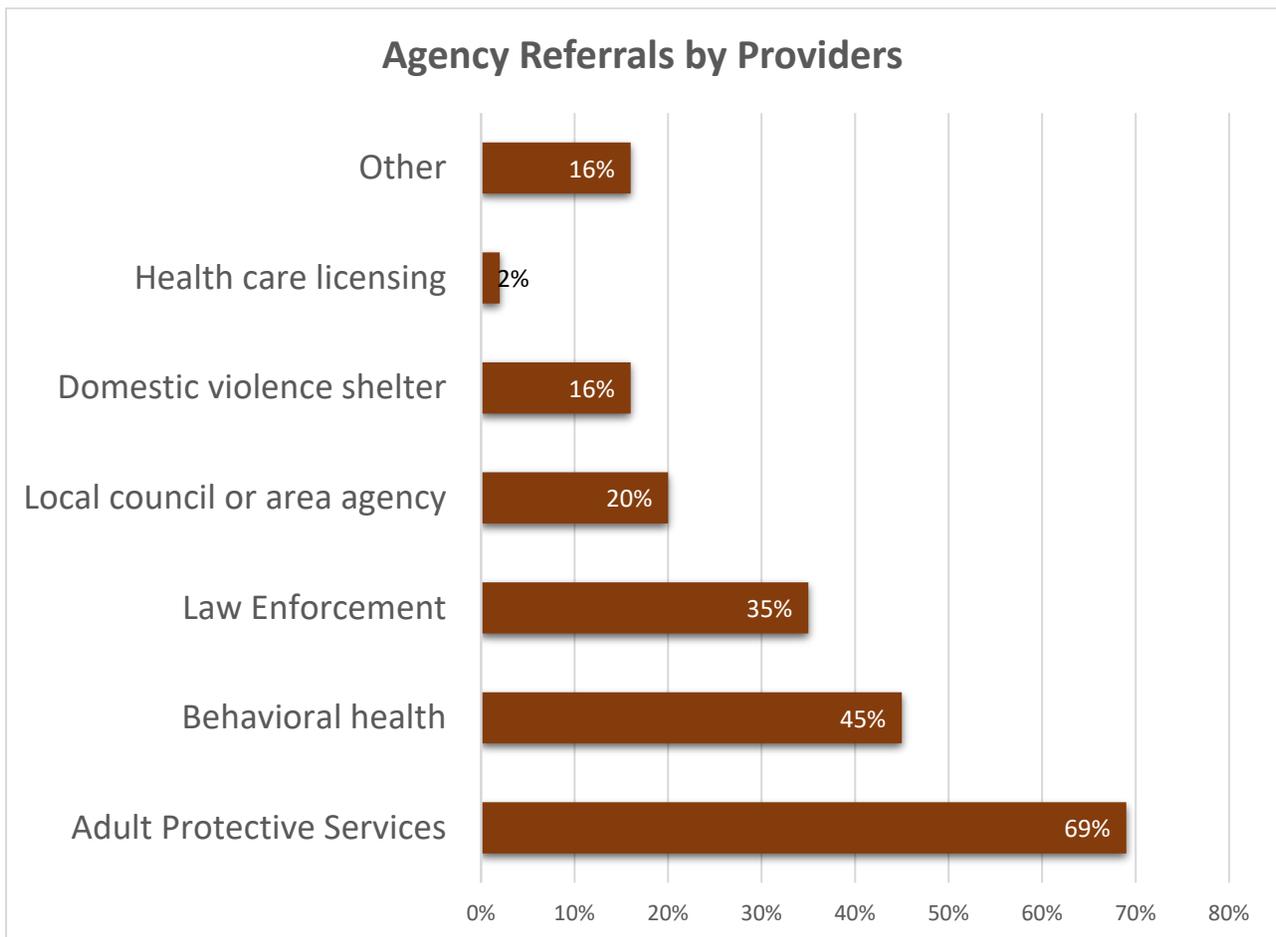
that traditionalism has an effect on the prevalence of elder abuse (40%). Respondents note that they believe traditional identification results in less abuse and is preventative, while acculturation increases the likelihood of abuse. They also note that there is more respect for elders in traditional native cultures. Substance abuse is also mentioned as a factor. The majority of respondents agree that differences in acculturation between caregivers and elders can increase the risk of abuse.



Forty-seven respondents listed additional significant factors contributing to elder abuse in their community. The most frequently occurring are substance abuse (25) and poverty (17). Other top factors include overreliance by the family on the elder, housing issues, lack of services, trauma history, and unemployment.

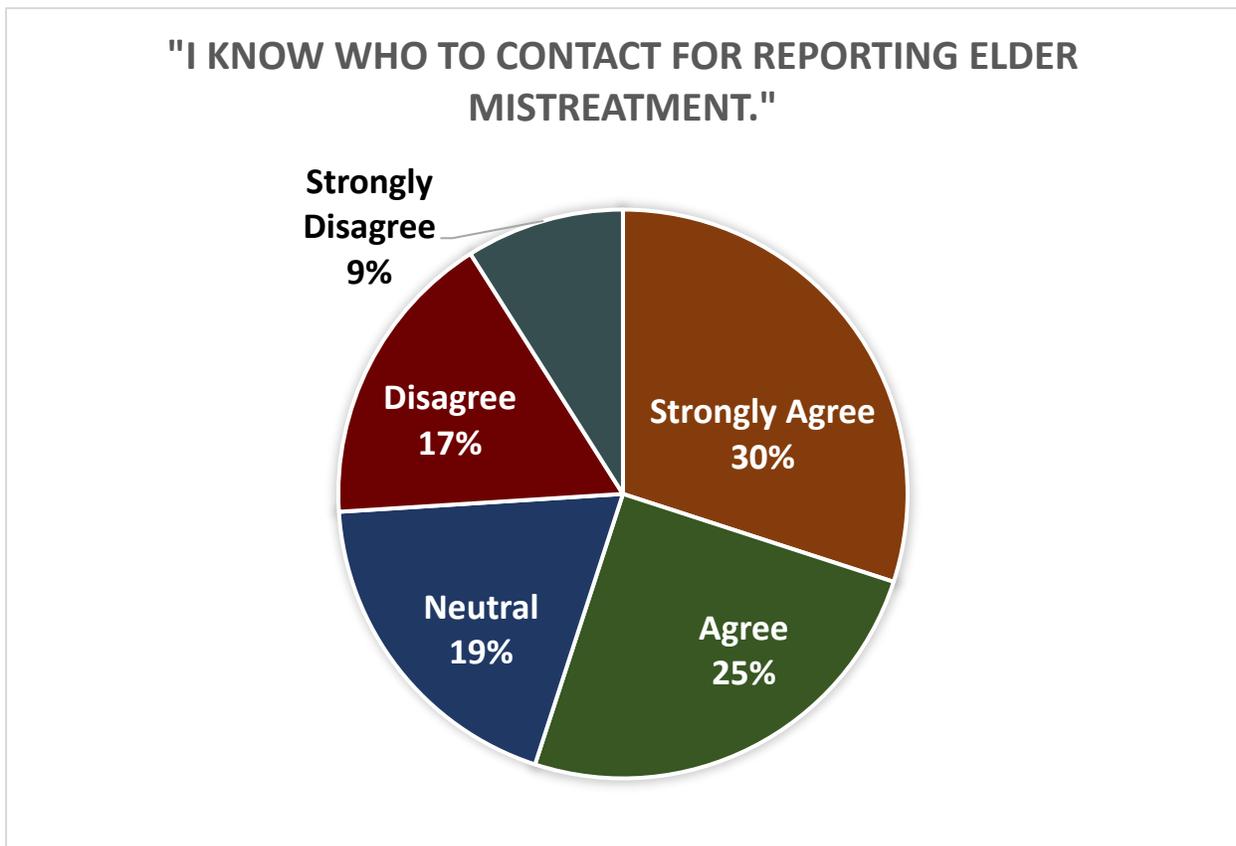
To begin looking at addressing the issue, respondents were asked about the community perception of elder abuse. Respondent most frequently note that communities are aware of elder abuse but have not done anything to address it. Others note no community interest, no community awareness, or denial by the community that an issue exists. The majority of respondents feel that there are not adequate resources to address the needs of elder abuse victims (49%) or do not know if there are adequate resources (29%).

APS is the most frequent resource respondents have used (69%) followed by behavioral health (45%) and law enforcement (35%).



In making referrals, the most frequent concern is no follow up or updates from the agency contacted. Other concerns are that nothing happened once referred and a

lack of training. Overall, the majority of responders feel they know who to contact for elder mistreatment reports (55% strongly agree or agree).



In community services, law enforcement, and government support for Native victims of elder abuse the most frequent gaps are in housing, resources needs in general, greater coordination between agencies and providers, and agency follow through

### **Comparison of Survey Findings to Interview Themes**

#### ***Individual Variables***

*Theme: Elder protection of family*

As in the interviews, survey respondents note elders are reluctant to make allegations against family members, particularly those who may be the elder's caregiver. This is one of the biggest barriers to addressing abuse. As one respondent notes, "The only willing caregiver may be the abuser, then [the] elder

will have no one to help them at all.” An added challenge is the presence of family members with the elder during clinic visits to provide transportation or other assistance.

*Theme: Elder support of grandchildren*

This was a theme that arose in interviews, but was not a significant theme in open ended survey comments or responses to other questions.

*Theme: Substance abuse as a contributing factor*

Unlike with interviews, substance abuse by the elder (not just family members or caregivers) is cited as a possible factor playing a role in abuse. AIAN communities have higher rates of substance misuse which reaches into the elderly as well.

### ***Familial Variables***

*Theme: Honor and duty to share resources*

As in the interviews, there is an overall theme of family dependence, predominantly children and grandchildren, on the elder. This theme is apparent as both a preventative factor and a contributor to abuse. As in the interviews, the cultural belief of respect for elders and family support is present throughout. This traditional family component is cited as a benefit over acculturation. The theme is also a potential contributor to abuse when family members are over reliant on the elder or feel “entitled” to this support. One respondent notes that it can be unclear when familial support can be of benefit or detriment to the elder.

*Theme: Caregiving creates vulnerabilities for some*

This was a theme that arose in interviews, but was not a significant theme in open ended survey comments or responses to other questions.

*Theme: Substance abuse as a contributing factor*

As with interviews, respondents believe substance misuse is the most significant risk factor for elder abuse. Abuse that results from substance abuse may be in any form, but frequently manifests as neglect or financial exploitation.

*Theme: Impoverishment as a contributing factor*

High poverty levels experienced by both the victim and the perpetrator contribute to abuse, particularly financial abuse according to survey respondents. Poverty is linked to the need for familial support which also contributes to abuse. Many AIAN communities face continuing poor economic opportunities and high rates of unemployment perpetuating poverty for generations beyond the elder. This is the same major sentiment shared in interviews.

## **Structural Variables**

*Theme: Patients present to providers with all types of abuse experiences*

As with interviews, survey respondents indicate that the easiest type of abuse for providers to identify is physical abuse (83%). This is followed closely by neglect (75%), according to survey respondents. Similarly, survey respondents have experience caring for patients with all types of abuse, though most frequent is financial abuse and exploitation, followed by emotional abuse, and neglect.

*Theme: Difficulties in abuse assessment*

*Theme: Providers can and should play a role*

As in the interviews, there is a consensus that there are barriers to screening and identifying abuse in the clinical setting. The most frequently identified barrier to the screening and management of elder abuse by survey respondents is presence of family members (44%), which was a primary theme in interviews. The interviews also identified time and provider turnover as key issues. Only 25% of survey respondents identified time as a barrier, however, and provider turnover was not an option in the question and not mentioned in open ended responses provided as follow up.

*Theme: Providers can and should play a role*

*Theme: Few standardized protocols*

Although the majority agree that providers are capable of and should have a role in identification of abuse, less than half note that their clinic routinely screens specifically for elder abuse. A lack of screening tools, lack of training on screening, and a lack of clinic screening protocols are major challenges. Among the seven responses on formal screening tools use only two were elder abuse specific, one of which addresses only women. These survey findings are all similar to interview themes that emerged.

Finally, the third most frequently cited barrier by survey respondents was lack of community resources. The need for additional services and resources was a theme identified in gaps and needs identified by interview respondents.

In addition to a lack of screening ability, there is evidence of a lack of formalized protocols to address suspected cases of abuse among survey and interview respondents. While only half cite the existence of a protocol, few cite clinics with best practices. The need for protocols and policies is the most frequent cited need. Current protocols largely include reporting to a variety of authorities or other agencies.

*New Theme: Awareness of abuse by providers not universal*

Lack of awareness by some providers of the abuse victims in their clinics is a response unique to survey respondents. While most providers acknowledge abuse cases in their clinic, about 20% report not having experienced a suspected case themselves or at their clinic.

### ***Cultural Variables***

*Theme: Respect for elders as a function of culture*

*Theme: Abuse discouraged as community /familial topic*

*New Theme: Traditional native cultures can both facilitate and protect against abuse*

Traditional native culture is generally viewed as a protective factor against abuse. Notably, in traditional culture elders receive greater respect and honor. Elders are seen as passing on knowledge and tradition to keep tribes safe and prosperous. However, the same traditional native cultural beliefs may play a contributing role to abuse in some cases. Household interdependence and high level of support for younger generations seen in traditional culture may be a risk factor for the elder. Additionally, elders may be reluctant to report or cooperate with outside agencies for the sake of protecting their family. All of these themes were identified by interview respondents as well.

While overall it is apparent that providers feel that traditional native culture is protective these are open to consideration.

*Theme: Role of acculturation is unclear*

*New Theme: Differing acculturation levels between elder and caregiver as a contributing factor.*

As most of the respondents note that their communities are not always fully traditional nor fully accultured, based on a line of questioning in the survey not pursued in interviews, there are cases where the elder and their caregiver differ in their cultural identification. Survey respondents strongly note that this difference can increase the risk of abuse. Traditional native culture can greatly differ from what is viewed as mainstream culture. Differing values between generations such as respect for elders or levels of family support may contribute to abuse by the caregiver. This was a sentiment a small number of interview respondents broached, though it was not a major theme. Among interview respondents, who were not asked to quantify their beliefs regarding acculturation, the role it plays in abuse was more ambiguous (maybe yes or not sure versus a definite yes or definite no), particularly among health care providers.

*Theme: Historical trauma*

Unlike in survey respondents, historical trauma was a major theme among interview respondents, though some discussions were the result of interviewer follow-up questions based upon participants who raised the subject in early interviews. The various concepts that encompass historical and present traumas (cycle of abuse, racism, historical trauma) were each mentioned by at least one respondent in surveys, but was not a major theme.

*Theme: Cultural renewal as possible intervention*

This was a theme that arose in interviews, but was not a significant theme in open ended survey comments or responses to other questions.

### **Community Variables**

*Theme: Community surveillance and identification*

This was a theme that arose in interviews, but was not a significant theme in open ended survey comments or responses to other questions.

*Theme: Lack of priority and awareness*

Within the communities served by respondent's clinics, there is a notable lack of awareness of or attention to the issue of elder abuse. Where communities are aware of the issue, it generally goes unaddressed. Denial or ignoring an uncomfortable problem contributes to this low level of engagement. There appears to be room for traction and growth as many respondents note that the community sees a problem but are not able to address it. These were major theme present in interviews.

*Theme: Promising interventions*

This was a theme that arose in interviews, but was not a significant theme in open ended survey comments or responses to other questions. While there was a survey question about best practices, there were few responses. If respondents did reply they indicated they did not know of any best practices.

## **Organizational Variables**

*Theme: Positive interactions with referral agencies essential, room for improvement*

As with the interviews, by and large survey respondents reported positive outcomes when working with APS, law enforcement, and other entities on referrals of abuse allegations. Nearly 70% of respondents have made a referral to APS, 45% to behavioral health, and 35% to law enforcement. Though, there were concerns expressed from a small number of respondents primarily related to lack of follow-up and concerns that “nothing was done” in response to referrals.

*Theme: Jurisdictional issues a challenge*

This was a theme that arose in interviews, but was not a significant theme in open ended survey comments or responses to other questions. There was a question with pre-identified barriers, and jurisdictional issues was not included, and there were only a few respondents who identified jurisdictional-related issues in the open-ended follow-up question.

## **Needs**

*Theme: Funding underscores multiple needs*

Contributing to the theme of lack of awareness and attention, there is a theme throughout the survey responses of a lack of resources in the community to address elder abuse. This lack of resources and funding is also seen in the interview analysis. The majority of respondents feel there are not a sufficient amount of resources to address the needs of older victims. A need for materials and educational resources for providers, victims, and the community is also seen.

*Theme: Need for additional training*

While providers feel capable, they need training. Unlike in the interviews, the majority of providers do not feel they had adequate training and similar to the interviews the vast majority would like to receive more training. Training suggestions differ, but the most frequent support the notion that providers are capable when given the tools. These suggestions include screening for abuse, identification, and resources for victims. Other areas of training that are more state or tribe specific include mandatory reporting requirements and investigative agency processes. These training topics also have the additional benefit of supporting greater collaboration.

## **Discussion**

The findings from this national needs assessment fill a significant void in the knowledge and understanding of the manifestation of elder abuse viewed through the lens of tribal health providers. It is the first assessment, to our knowledge, of its kind. It utilizes two complementary methods of assessing similar questions and issues that results in rich, descriptive stories and examples that give a real voice to the needs and challenges faced by tribal providers. Using multiple methods of inquiry, we were able to triangulate most findings which is demonstrated through the remarkable congruence between survey results and the interview findings. Though there were a number of themes that were identified in interviews that were not identified across survey data, and a smaller number that were identified in the survey but not interview. While survey respondents were provided multiple opportunities to provide comments to specific questions and more generally, those answers tended to be very succinct and often provided little context or description of issues that were raised. Such is the nature of survey responses.

### **Screening is Widely Accepted, But Not Being Widely Accomplished**

Of prime importance to our overarching goal, which is to promote and implement screenings, referrals, and/or interventions for AIAN elder victims of abuse, is that 89% of survey respondents agree that all health care providers should play a role in screening for elder mistreatment. Yet, only 54% of survey respondents report they routinely screen for elder abuse and only two interview participants (from the same tribe) report implementing an elder-specific screening tool and only one interview respondent reports implementing an elder-specific screening tool (within the last year). The desire for systematic provider engagement in screening is a sentiment generally supported in interview findings. While there are those who, through both methods of inquiry, express doubt, concern, or disagree with the concept of provider screening for elder mistreatment, they comprise a small minority.

### **Desire for Training, Protocols and Tools**

However, findings also clearly indicate that at the present time the majority of providers lack the knowledge, training, appropriate tools or protocols, and community resources to properly equip them to respond. All the while they continue to care for elderly patients who they believe are being abused or exploited. Nearly 70% of providers have worked with patients experiencing financial abuse or exploitation according to survey results, and more than 60% have patients who have experienced neglect or emotional abuse. An astounding 43% of providers have encountered patients experiencing physical abuse, even though it is one of the less common forms of abuse. Yet in the face of these experiences, providers are largely left to fend for themselves in assessing and managing suspected cases of abuse and exploitation and generally lack the appropriate community services (as a means of intervention).

## **Findings Confirmed by Previous Research**

Beyond screening, there are a number of findings from the current needs assessment that support previous elder abuse research or expert opinion in AIAN focused research. For instance:

- financial exploitation and neglect are cited as the most prevalent forms of abuse by health care providers
- substance abuse and poverty are thought to be the two most common correlates or causes of abuse; followed by mental health issues
- respect for elders is the predominant cultural value discussed in interviews and surveys
- jurisdictional issues are a significant challenge according to interviews
- communities with more traditional views and that are less acculturated are thought to experience lower rates of abuse; conversely acculturation is thought to lead to higher rates of abuse though there were mixed findings on the part of some health care providers who see instances of abuse regardless of the degree of acculturation or traditionalism

## **Noteworthy or New Findings**

There are several issues, which may have been broached in previous research or opinion pieces about elder abuse in AIAN communities that we believe warrant further discussion.

### *Historical and Current Traumas*

Historical and current trauma, which have been discussed in previous abuse research among AIAN elders, though not a major theme or aspect, is a major theme in our interviews that is unique to the population. Boarding schools, the life cycle of family violence, persistent racism, and forced assimilation or acculturation are among the

important issues identified by multiple respondents. As previously discussed in this report, the scope and duration of historical trauma experienced by the AIAN population is unique. As shared by interview participants in the current assessment, there are tribal elders alive today who were subjected to boarding school experiences, which existed until as late as the latter half of the last century and still others who continue to face persistent discrimination in their communities. Historical trauma couples with higher rates of trauma and adverse experiences across the lifespan. Research has shown that AIAN people experience higher rates of adverse childhood events (ACEs) (Kenney & Singh, 2016; Warne et al., 2017), a topic raised in two interviews in the present study. Recent analysis of the National Elder Mistreatment Study dataset found that 79% of all AIAN respondents had experience some form of trauma in their lifetime (e.g., natural disasters, accidents, or other situation they feared for their life); a significantly higher percentage than their white counterparts in the study (Crowder et al, 2019). Based on data from the same analysis, we know that AIAN elders in that study experienced higher lifetime rates of various types of abuse when compared with whites and were also significantly more likely to experience polyvictimization (multiple types of abuse) than white counterparts in their lifetime.

The importance of the concept of polyvictimization and the dose-dependent response to exposure to multiple episodes of victimization is emerging in elder abuse research (Burnett et al., 2016; Hamby, Smith, Mitchell, & Turner, 2016; Teaster, 2017). Polyvictimization enhances the likelihood of psychological issues such as depression, anxiety, PTSD, other psychiatric diagnoses or suicidal ideation (Tossone, 2015), any or all of which can significantly impact physical health and wellness. Much like polyvictimization, the body on trauma or trauma-informed care among victims of elder abuse is sparse. Even less is known or written about the impact of compounding both historical and

current life victimization and traumas, only that it occurs and is worthy of attention. Gustafsson et al. (2009) coined the term poly-traumatization, one not widely discussed in the scientific literature and essentially absent from the elder abuse literature. The term encompasses the co-occurrence of multiple types of victimization and traumatization such as family deaths, car accidents, or divorce.

The concept of trauma informed care and the importance to the practice of working with elder abuse victims was raised by several interview respondents. As one participant noted, they have been practicing facets of trauma-informed care in their tribe for some time, but only in more recent years has someone put a formal name to the concept. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has outlined six key principles of trauma informed care (SAMHSA, 2014). SAMHSA indicates that these practices are integral not just in behavioral health settings, rather implementation is essential in any setting a person who has experienced trauma comes in contact, including primary care. Further, they state that not addressing trauma as part of the provision of care is a barrier to good patient outcomes.

As it was not the focus of the current project, it is not known how broadly trauma informed care practices are employed across health sectors that serve tribal populations. The IHS website describes details about the “Trauma Informed Care Project,” offered through the Division of Behavioral Health, with archived training resources from 2013 -2017 and notes the availability of two providers for case consultation services (U.S. Indian Health Service, n.d.). Many of the training resources are focused on children and youth, though several focus on veterans and historical trauma. No participants in the current needs assessment referenced formal training, and it is unclear if the IHS Trauma Informed Care Project is still an active initiative offered by IHS. Health care providers and clinic staff, as well as elder

advocates and APS staff, may benefit from training and exposure to trauma-informed care practices and protocols, if not already provided, with focused content for elder tribal members and elder abuse victims. Like training in the recognition and response to elder abuse and exploitation, learning, understanding, and integrated trauma-informed care into clinical practice will require a systematic approach to implementation, but seems a logical adjunct to any planned effort to address elder abuse given the pervasive nature of the issue.

### ***Poverty and Other Social Determinants of Health***

Marked disparities exist for elders regarding the social determinants of health. When we examine the social determinants of health in regard to AIAN, Indigenous, and other colonized peoples, it is apparent that among elders (defined by the IHS as >55 years of age) within these populations many experience “multiple jeopardy.” They are often politically disenfranchised, either presently or historically, are often poverty-stricken, and are in poor health, when compared to their counterparts in the general population (Sokolovsky, 2009; Henderson 2002; 2010). When we look at the elders as descendants of a long history of structural violence then we expand the multiple jeopardy concept exponentially.

The older AIAN population, will increase by 193% by 2030 (Administration on Aging). The fact that minorities are often more vulnerable to health and well-being deficits than the majority population coupled with significant increases in minority populations, means health care and social systems face a disparity crisis regarding health, aging, and minority status (Henderson and Henderson, 2008). Issues such as the ones discussed in our interviews about the perceived causal relationship of poverty, substance abuse, and other mental health issues, along with concerns about current funding deficiencies for elder services including community health,

behavioral health, and access to other community and health services for elder victims of abuse that will only compound as a result of these demographic shifts.

The IHS is currently confronted with the problem of providing care to the increasing numbers of elders, without having sufficient resources to care for the other age groups within the Indian population. IHS delivers free health care services to the Native American population who are members of federally recognized tribes that live in proximity to facilities that are geographically accessible. Funding for services is often deficient for its population needs. IHS services are an entitlement, and therefore the U.S. Congress makes funds available through an appropriation. HIS areas operate for the most part on limited budgets. There are expensive diagnostic and treatment services that are contracted for with other providers, but these become unavailable if the budget is insufficient (Henderson, 2001). The Indian Self-determination Act places the responsibility for almost half of health programs on the tribes. In many cases, reimbursement from the federal government is low, and this places the tribe at a financial disadvantage. Self-determination has inflated costs and compromised service provisions, due to lack of coordination between, federal, state and tribal agencies (Henderson, 2001).

Additional services essential to the health and wellbeing of Indian elders also face substantial deficits in funding and access. Long-term care is needed increasingly in Indian country, as more adult children find it necessary to move from rural areas to urban areas, in order to find employment. Multiple interview respondents discussed concerns about the lack of access to long term care facilities for out-placement of abused tribal elders to remove them from unsafe situations, and lack of respite care for over-burdened spouses and family caregivers. Caregiving issues such as increased dependency patterns of older adults or the complexities associated with sharing family caregiving roles, have been identified in previous elder abuse

research among AIAN communities. However, caregiving issues were not as prominently discussed among participants in this assessment. Often, discussion of caregiving issues arose when participants were asked to share an example of a case of elder mistreatment. In many of those anecdotes, the caregiving responsibility fell to adult children or grandchildren and multiple cases involved elders with dementia or Alzheimer's disease. The children as caregiver theme is not surprising though, given that a smaller percentage of AIANs age 50 and over that are married or co-habiting compared with the rest of the U.S. population (Goins et al, 2015). These were often cases identified as "gray areas," where it was not always a clear-cut case of abuse or exploitation, rather a question regarding the need for additional services or resources such as home health care, homemaker services, respite care, or food and nutrition services.

Access to housing, food, and transportation were also service deficits identified by respondents.

The Older Americans Act mandates that certain services be provided to elders through Title III for the general population, and Title VI for the Indian population. These two acts differ significantly in the services that are mandated by the grants. Title III mandates that nutrition sites, home delivered meals, in-home services, transportation and access services, legal assistance, and ombudsman services be provided by the area program. In 2016, the Title VI programs served 64,464 older Indians meals in congregate sites such as senior centers and provided home-delivered meals to an additional 24,810 Native elders, in addition to the provision of other services both in-home and in senior centers. Title VI services presently offer the most systematic access and provision of services to and for AIAN elders, yet are not available in every tribe or village. For AIAN elders, however, Title VI mandates only that nutrition sites, referral and information services, and transportation be

provided. Title VI is grossly under-funded, and even the services vary greatly between tribes.

### *Community, Public Health and Home Health as Surveillance & Intervention*

Community Health Representatives (CHRs) and home health nursing programs came up frequently, identified as sources of surveillance and screening in the community as well as “interventions” employed in cases of alleged or confirmed abuse. Home health staff were often identified as the “eyes and ears” in the community.

The CHR Program is a unique community-based outreach program, staffed by a cadre of well-trained, medically-guided, tribal and Native community people, who provide a variety of health services within AIAN communities. A CHR may include traditional Native concepts in his/her work and is funded with IHS-CHR appropriations (L.C. Carson, 2010). There continues to be a crucial shortage of home-health services for the elderly as fewer services funded and delivered by the IHS are community-based. There is a lack of financial support for ongoing service provision as well. Home care is provided by IHS, tribal health nurses, Public Health Nurses (PHNs) and CHRs. Public health nurses and CHRs are important sources of care for the elders because both make home visits and transport elders to health care facilities. The CHR program provides a cost-effective means to provide case management and home-health care for this population. However, the current demand for transportation and the need for specific training in geriatrics mitigate against further use of CHRs for this purpose (Carson, 2001). Several respondents indicated that standard home health resources funded by Medicare, for instance, could be hard to obtain or of such a short duration or intensity they provided little assistance. One urban Indian health center discussed with regret that their clinic-funded home health program had recently been cut and would stop providing services in the near term. This was perceived as a catastrophic cut in a valuable

resource as traditional publicly and private funded home health programs failed to provide the quality of service and intervention in a culturally sensitive manner. A systematic assessment of how to better leverage Medicare home health resources in cases of alleged or confirmed abuse may be warranted. In addition, assessing opportunities to initiate or expand tribal-run home health programs, including innovative funding models, to aid in assisting not only victims of elder abuse but other epidemic-level health issues such facing tribal elders and communities such as Alzheimer's and dementia.

Development and assessment of potential screening and intervention programs using home-based health service staff would be both innovative and warranted based upon findings from interviews. One such evidence-based model, the Domestic Violence Enhanced Home Visitation (DOVE) program could serve as a potential model. DOVE is an IPV intervention to reduce violence for prenatal and postpartum women with documented or high risk of IPV (Sharps et al., 2016). The DOVE intervention includes structured abuse screening for IPV and a six-session empowerment intervention. It is delivered primarily by nurses as part of a pre-existing home visiting programs. Staff received initial and ongoing training and support. Each of six sessions consisted of a review of a simple brochure on the cycle of violence, an assessment of risk factors, review of available resources, and safety planning. Staff were encouraged to modify the content of discussions to meet the needs of the patient and situation encountered in the home (Bacchus et al., 2016).

### ***Need to Explore the Link Between Culture and Abuse***

Previous research has identified acculturation and assimilation as potentially causative factors for abuse, as a result the subject was incorporated into the present study (Baldrige et al., 2004; Baldrige, 2001; Hudson, Armachain, Beasley, &

Carlson, 1998; Jervis & Sconzert-Hall, 2017; Maxwell & Maxwell, 1992). Most non-health care providers were likely to indicate when asked that acculturation increased the potential for abuse, whereas health care providers were more likely to indicate it had no impact or the impact was unknown. The latter responses may be related to the high percentage of non-health care providers who identify as AIAN, thus, as a tribal member themselves they are more attune to issues related to culture. If the questions surrounding acculturation and traditionalism had not been included, it is unlikely that few participants would have raised the issue in interviews or surveys. Other than recognition of the issue, we simply know very little about the real impact of the issue on abuse. There are more questions than answers based upon existing literature. Does acculturation really make a difference when it comes to elder abuse? Is the impact direct or indirect? Are there important mediators and moderators? Does it matter “who” is more traditional, more mainstream or bicultural as proposed by our survey respondents? Does acculturation matter at the community level or individual level?

Relatedly, several participants mentioned programs designed to reinvigorate cultural traditions such as language, culture, and food programs. These are posited as potential promising or best practices. A similar series of questions exist to explore the potential link to abuse or abuse prevention so we can better understand the mechanism of impact, if any. These programs may offer the opportunity to meaningfully engage elders and to reduce social isolation. Perhaps the impact is one of self-empowerment of elders or changing behavior or offering early interventions for potentially abusive family members. There are validated available tools to measure acculturation and assimilation among AIAN people. There are validated tools to measure elder abuse. There are programs in place

focused on re-vitalizing culture. One needs only to invest in an assessment that brings all of these concepts and practices together.

### ***MDTs, Another Promising Intervention***

MDTs were another promising practice discussed in our interviews. In those tribes where they exist, they are seen as a very effective tool. Notably, virtually all of the communities who have an existing MDT also have a tribally-funded APS worker or another individual who serves as a single point of contact for alleged cases of abuse. These tribes also appear to employ the most comprehensive response to elder abuse when it occurs, and have the ability to engage multidisciplinary resources on behalf of elder victims. This is as opposed to relying on county or state APS workers or even a tribal social services staff member or social worker or department who had dual responsibility for both child and elder abuse complaints.

A brief survey of 265 Title VI (elder services) program staff was conducted by as part of an informal assessment for a different project being undertaken. Of those responding, 20 tribal MDTs or other formal or informal boards, special councils or entities made up of multidisciplinary staff that regularly discusses and works with victims of elder mistreatment was identified. Forty-seven percent (47%) of 62 tribal elder service respondents also indicated that they had tribally funded APS staff, while 53% rely on county, state, or other non-tribal APS programs to refer and manage alleged cases of elder abuse or identified some “other” staffing scenario.

The existence of MDTs and other structural and community supports in tribal communities is sporadic and has not been assessed systematically. Based on brief discussions of MDTs as part of interviews for the current project, we found that what constitutes an MDT and the roles and functions of the teams varies from one tribe to the next. Discussions with tribal staff indicate that membership, function, and

outcomes of these MDTs vary. We also found that the tribal provision of services may include non-traditional services such as home repairs and transportation.

However, the evidence-base supporting the use of MDTs includes only a handful of case studies or quasi-experimental research. What exists, seems to indicate that MDTs may be effective in enhancing coordination, increasing knowledge of professionals, better leveraging fragmented resources, and improving outcomes. In their international review, Pillemer and colleagues note that the needed response to aid victims of elder abuse spans multiple systems, such as health care, APS, mental health, criminal justice and more. They also advised, relevant to previous discussions in this assessment, that MDTs implemented in lower-income countries were likely to face significant barriers as services for victims must first be available before MDTs can be successfully implemented (2016).

In 2019, the Office for Victims of Crime (OVC) issued a solicitation for proposals to fund 10 – 22 enhanced MDTs (e-MDTs), with up to 10 of those in tribal communities, and a national training and technical assistance center to support the OVC funded e-MDT program (Ivkovich 2019). The program and dedicated funding for tribal entities holds great promise. However, tribal-run programs have, in the experience of our project team, historically faced many barriers responding to traditional federal public solicitations. In addition, some tribal entities we spoke with about the funding announcement expressed concern that it appeared to require “enhanced” staffing models that may be out of reach for typical rural tribal-run MDTs. Coupled with a relatively short turnaround time for proposals, there were a number of barriers that may have ultimately limited tribal response to the first round of solicitations due in July of 2019. That said, any systematic assessment of processes, protocols and promising practices specifically within tribal MDTs will yield a significant contribution to the field and to tribal communities. Optimally, additional

future additional opportunities will be made available to aid in establishing and managing MDTs (and other promising practices) with designated set asides for tribes and tribal entities. For tribes unable to respond to large, formal solicitations, alternative funding strategies to establish for improve MDT operations may be sought.

### *Self-Neglect Largely Absent in Assessment, But A Significant Issue*

Finally, self-neglect was not specifically included in interview or survey questions, though was an issue raised by several interview participants. Self-neglect was not included in this needs assessment due to its unique nature and lack of an outside perpetrator. While social service providers and researchers generally incorporate self-neglect with other types of abuse, is often excluded from research in the justice field owing to the lack of a perpetrator. However, the U.S. Department of Health and Human Services, Administration for Community Living's (2016) Voluntary Consensus Guidelines for State APS Systems, includes self-neglect as an area to be addressed by APS programs. Self-neglect is the primary type of elder abuse cases reported to APS and can be the most complex to address (Dong, 2017). Given the high prevalence and association with other forms of abuse such as financial exploitation, providers are likely to encounter self-neglect in their clinical practice. This is an area worthy of consideration for future work.

### **Policy and Practice Recommendations**

Based upon finding from this needs assessment, with some integration of findings in the existing literature elder abuse literature specific to AIAN elders, the following set of policy and practice recommendations are offered. Recommendations are offered for consideration by tribes, counties, state, and federal level policymakers and health care practitioners. The list of recommendations is offered in no particular order of priority, **though findings from the present needs assessment indicate**

**that screening tools, protocols, and training are the most pressing priorities for health care providers.**

- Development or adaptation of a tool or best practices to systematically assess community supports, services, and assets for tribal health providers and elder abuse victims available within or adjacent to tribes and to tribal-serving health care entities
- Dedicated tribal-funded APS staff person, social worker, case manager, or elder service worker with APS-type roles and responsibilities (in tribes that do not currently have this type of position)
- Enhance or establish relationships between existing tribal and county APS and MDT programs and outpatient tribal health centers to promote regular opportunities for training and ongoing support of clinical staff referrals; incorporate health center staff into existing MDTs
- Initiate or enhance tribal-run CHR and/or home health programs, or identify alternative funding streams to make current programs solvent
- Standardized provider training on elder abuse assessment and management that addresses complicated cases, red flags, and “grey areas” that incorporates a trauma-informed care approach specific to the needs of AIAN elders
- Selection and testing of elder-specific abuse clinical screening tool including short- and long-term outcomes in tribal clinical setting
- Testing/adaption of tools specific to AIAN elders to be cultural appropriate and specific
- Development of standardized screening protocols for assessing abuse and exploitation in older adults that is adaptable by local tribes and health providers
  - Outpatient clinic settings

- Home-based care settings
- Training on effective use of standardized screening protocol
  - Health centers: health care providers, nursing staff, social workers/ case managers, auxiliary health providers situated in clinics that have direct patient contact
  - Home-based care programs: CHRs, public health nurses, home visiting nurses and auxiliary staff
- Development of standardized intervention protocol that is adaptable by local tribes and health providers
  - Training on effective use of intervention protocol
  - Potential interventions identified in the present study include:
    - Assessment of multidisciplinary service and support needs
    - Referral to APS – relationship development, communication, and jurisdictional issues
    - Referral to law enforcement – relationship development, communication, and jurisdictional issues
    - Referral to additional agencies or departments
    - Placement in respite or other facility or shelter for safety
    - Training on roles, processes, policies of other agencies (i.e. depending on statute/regulation APS can't give out information on cases and may not even be able to confirm an investigation is taking place; how providers can and should follow up or documentation needed)
- Support for existing MDTs and expansion to new tribes for assessment, development of an action plan and systematic approach to MDTs as an elder abuse intervention. Consider process specific evaluation or assessment to identify:
  - Membership

- Frequency of standard meetings of MDT
- Interventions employed
- Process to manage follow-up actions (for example, home visit, post-APS or Law referral, additional interventions)
- Communication and collaboration protocols
- Development and empirical testing of strategies to enhance community outreach, awareness, and reporting of elder abuse
  - Identification of strategies to increase tribal leadership buy-in
- Empirical assessment of the direct and indirect impact on elder abuse and exploitation of programs designed to promote cultural revitalization.

## **Conclusion**

The present project employed a mixed-methods approach to assessment of facilitators and barriers to outpatient tribal health care provider engagement in screening and systematic management of the needs of elder victims of abuse encountered in daily practice. Great congruence between interview and survey findings occurred, however, interviews provided greater depth and opportunities to assess potential promising practices. Interviews also created the opportunity discuss more complex issues such as acculturation and historical trauma, both culturally-specific and significant issues in the context of tribal communities. Most important, we found by and large outpatient tribal health care providers who participated are willing and ready to embrace screening for abuse among their older patients and community workers believe it is a role they should play. These same providers are already forced to intervene in clinical settings that more often than not lack proper protocols for managing cases of elder abuse, offer little training, and either lack information about available community services or supports or lack the actual community services and supports.

Some findings from this assessment are reflective of previous elder abuse research inclusive of AIAN communities, or support findings from research among mainstream populations, e.g., provider barriers to screening. However, our project team believes the needs of tribal elders are unique, and the needs of each of the respective tribal clinics, villages, and communities is unique when it comes to addressing the issue of elder abuse. Systems, protocols, services, and supports must be designed and implemented ideally by tribes and tribal providers themselves or at the very least in close collaboration. Though, we offer a set of general recommendations based upon the convergence of the experiences of the tribal health providers and non-health care providers who participated in this project from across the country. This report addresses the original projective objectives, we: identify multiple factors that contribute to elder abuse identification and management, identify facilitators and barriers for tribal providers, share insight into the phenomenon of providing care for AIAN elders, identify important cultural factors, and discuss several existing and promising practices being employed by tribal health care providers. To the extent possible, we use the words of tribal providers and elder advocates themselves to substantiate our findings. Our hope is that this report is a stepping-stone to future conversations about how to address the epidemic of elder abuse facing tribal communities.

### **Limitations**

As with any field research or needs assessment, limitations exist that impact the overall conduct of the research and analysis of the findings. Respondent selection utilized non-random intensity sampling. Intensity sampling requires that those respondents that are included in the study possibly have experiential knowledge of (in this case) usual care in the tribal health work environment with some knowledge of surveillance practices for elder abuse as compared to those who have limited or

no experience. The intensity sampling technique employed was without selection bias in regard to the researcher. Additionally, the sample was considered to be a convenience sample, in that respondents were from lists presented to IA2 by contacts from various organizations.

Inclusion in the research was based upon 1) experience with tribal health work environment, 2) availability on the day interviews were being conducted, and 3) willingness to participate. Participants were included in the assessment on a voluntary basis, as such there was likely some degree of selection bias on their part, meaning overall the group was likely more interested or had a greater degree of experience with elder abuse than the typical health care provider. It is not known if informants chosen by another selection process would differ from those who were recruited by the researchers.

The interview and survey samples were small relative to the research methods employed and the universe of potential participants (which is assumed to be vast, but is unknown), particularly the survey. Though, both PIs independently confirmed that saturation was reached during interview data analysis. Respondents varied widely. The majority serve rural populations, though interviews included three urban Indian health center providers. Survey respondents represented a more diverse subset of geographic coverage and tribal versus IHS management. The universe of all tribal health organizations was not accessed.

Objectively quantifiable measures of elder abuse screening frequencies and interventions were unavailable for this study as this was the first study of its kind. Medical records were not accessed for this research. If medical records had been used, a more accurate measure of elder abuse assessment and intervention would have been evaluated.

While efforts were made to accurately represent the lived experiences of interview participants, there is likely a degree of distortion between researchers' observations and analysis and representation. While both principal investigators have some degree of experience working with AIAN populations, both are Caucasian females, and themselves trained health care providers, which likely influence, to some extent, their analysis and conclusions. There was some evidence of social desirability bias on the part of interview participants when data on certain questions was triangulated with data from the health care provider survey. Social desirability bias is the tendency of participants to respond in a manner that they think is more acceptable to the interviewer, particular in the case of sensitive questions. For example, interview participants were more likely than survey respondents to say they had adequate training in elder abuse detection and management, though both groups had a relatively similar % of participants who indicated they in fact wanted more training. Several methods were employed to minimize the degree of social desirability bias for interviews (careful attention to question phrasing, prompts to ensure confidentiality, and triangulation of findings with survey data), however, it is an inherent challenge with qualitative research methods.

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## Appendix

### Tribal Health Provider Interview Guide

You have been asked to participate in a project about abuse of American Indian elders and how that is managed in health care providers who primarily work with American Indian or Alaska Native patient populations. We are talking with physicians, nurse practitioners, physician assistants and social workers to learn more about their experiences in the outpatient setting. You were identified as a key clinic staff person.

The interview will take 1 – 1.5 hours and will be recorded so we can create a written transcript of your comments for our analysis. Because the interview is about elder abuse, which can be a sensitive subject, there may be questions that make you feel uncomfortable. You can refuse to answer any question and may withdraw from the interview at any time, if you wish.

The interview results are **anonymous**, your individual responses are confidential and will only be reviewed by staff from the International Association for Indigenous Aging. Summary results will be shared in issue briefs and other resource documents, but only in aggregate form. Responses will never identify a provider, tribe, or clinic/ health care setting by name.

After we have finished interviewing all of our participants, we will share our preliminary analysis with participants to solicit their feedback on our findings. Your review of this information is not required, but I hope you will take the opportunity to participate in that review.

I will be recording our conversation today.

Do I have your permission to proceed with the interview?

## Relevant experience

1. Tell me a little bit about yourself and your role at your clinic
2. Job title/role
  - a. Physician
  - b. Nurse practitioner
  - c. Physician's assistant
  - d. Social worker
  - e. Other, please describe
3. How many years have you worked at the current outpatient clinic/practice?  
(please enter a number only; e.g., 6 years, 6 months = 6.5)
  - a. [Number only]
4. Are you American Indian or Alaska Native yourself?
  - a. Yes
  - b. No
5. What types of services does your outpatient clinic/ office provide? (check all that apply)
  - a. Primary care
  - b. Specialty clinic/services
  - c. Behavioral health services
  - d. Referrals only
  - e. Other, please specify
6. What state is your office located in?
7. Do you serve a primarily rural or urban population?
  - a. Rural
  - b. Urban
  - c. Suburban
  - d. Other
8. Is your clinic / practice managed:

- a. Indian Health Services
  - b. Tribe(s)
  - c. Non-native entity
  - d. Other, please specify
9. What populations are served by your clinic / practice?
- a. American Indian and Alaska Native only
  - b. American Indian and Alaska Native AND non-Native populations
  - c. Other, please specify
10. Does your clinic / practice serve primarily one tribe or multiple?
- a. One tribe
  - b. Multiple tribes
11. Approximately what percentage of the patients you see are 60 years and older?
- a. 0 – 10%
  - b. 11 – 20%
  - c. 21 – 30%
  - d. 31 – 40%.
  - e. 41 – 50%
  - f. 51 – 60%
  - g. 61 – 70%
  - h. 71 – 80%
  - i. 81 – 90%
  - j. 91 – 100%

**Experience with elder mistreatment/abuse**

12. What are your thoughts about elder abuse in the Native community served by the clinic?
13. How do you personally define elder abuse or mistreatment?

14. Elder abuse can account for an array of types of mistreatment- neglect, financial, physical, emotional, sexual, etc. Are there certain types of abuse you have found to be more prevalent in your experience working with tribal elders?
  - a. Do you think outpatient providers are capable of identifying different types of abuse? Are they better able to identify some types of abuse vs. others?
15. To what extent do you agree or disagree with this statement: Outpatient providers are capable of identifying all different types of elder abuse?
  - a. Strongly disagree
  - b. Disagree
  - c. Neutral
  - d. Agree
  - e. Strongly agree
16. Can you tell me about a situation you encountered in your clinical practice with a patient who you thought or confirmed was abused? Please be reminded not to use names or other identifying information for patients or providers involved in this situation.
  - a. What is the protocol for handling this type of abuse in your clinic?
  - b. Do you feel like the situation was handled well/ not well?
17. Just a reminder our conversations are confidential and findings are anonymous, and we ask that you not use patient, provider or clinic names. Can you describe a case where you feel like it was/wasn't handled well in your experience as clinical provider? [if previous question was handled well, this question should focus on opposite, vice versa]
18. Do you feel you have adequate training in elder mistreatment detection, management and reporting?
  - a. Yes

- b. No

### **Process for screening and interventions**

- 19. Would you like to receive training in elder mistreatment, detection, management and reporting?
  - a. Yes
  - b. No
- 20. Does your state require mandatory reporting in suspected cases of elder abuse?
  - a. Does the tribe (if the clinic is tribal run/specific)?
  - b. Are there any legal/procedural conflicts between state mandatory reporting laws and your work with/for a tribe?
- 21. Can you describe any screening processes or tools you or the clinic use to evaluate elder patients for abuse?
  - a. [If none] What role do you think you clinical providers should play in screening for elder abuse and mistreatment?
- 22. What, if anything, makes screening for elder abuse hard to do in your clinic? What barriers do you face?
- 23. What happens in your clinic after a suspected case of abuse is identified?
  - a. Does your clinic have staff to assist?
  - b. Do you refer out?
  - c. [If you aren't interviewing a social worker, ask...] Do you have social workers on staff who assist?
  - d. Does your clinic have any interventions they can employ directly in these situations?
- 24. Can you describe an intervention or interventions you use in your clinic for managing suspected cases of elder abuse?

25. If you could design an ideal program for screening for and managing suspected cases of elder abuse, what would it look like? What tools, policies, processes or structures...
26. What resources, information or support do you need to better manage suspected cases of elder abuse?
27. Do you have examples of clinic or practices (including your own) that you feel employ best practices in screening for and managing suspected cases of elder abuse?

### **Cultural beliefs and practices related to elder mistreatment**

28. What are the strengths of the Native elders, people, and families served by your clinic?
29. Do you feel as if the community members you serve are more acculturated (more mainstream beliefs) or more traditional (strong Native cultural identity)?
30. What role or impact do you think acculturation has on elder abuse prevalence?
  - a. Do you think acculturation makes a person/family more or less likely to experience abuse?
31. Generally speaking, how are tribal elders perceived in the community served by your clinic?
  - a. Revered? Respected? Maternalistic? Paternalistic?
32. [If they say elders respected/revered...] What are your thoughts about why elder abuse still occurs in your community / patient population if the community holds elders in high regard?
33. There are many societal, family and personal factors that can play a role in or contribute to elder abuse in any population or community? What do you

think are the most significant factors in the Native community your clinic serves?

34. How do you think the local tribal community/communities perceives the issue of elder abuse?

**Community resources and gaps in support**

35. What resources are there in the community to support victims of elder abuse?
36. Have you ever made a referral to adult protective services? Can you describe how you felt that worked?
37. Have you ever made a referral to law enforcement for suspected cases of elder abuse? Can you describe how you felt that worked?
38. Have you ever made a referral to another entity for suspected cases of elder abuse? Can you describe how you felt that worked?
39. What do you believe are the major gaps in resources needed to support Native victims of elder abuse?
40. Is there anything we haven't talked about or that you would like to add to any of your earlier answers?

## Tribal Health Provider Online Survey

We are seeking outpatient health care providers to participate in an anonymous survey about experiences with abuse of American Indian and Alaska Native elders. We are specifically seeking to learn more about how potential elder abuse is managed by outpatient providers who primarily work with American Indian or Alaska Native patient populations.

**The survey is intended for physicians, nurse practitioners, physician assistants and social workers to learn more about their experiences in the outpatient setting.**

The online survey will take 15 – 20 minutes.

Elder abuse is a sensitive subject. A provider and clinic's management of abuse can also be of a sensitive nature. We want to encourage your open and honest response.

**The survey is anonymous**, your individual responses are confidential and will only be reviewed by staff from the International Association for Indigenous Aging.

Summary results will be shared in issue briefs and other resource documents, but only in aggregate form. Responses will never identify a provider, tribe, or clinic/ health care setting by name.

If you have questions or concerns, please contact Kendra Kuehn at [kendra@iasquared.org](mailto:kendra@iasquared.org).

\* 1. Do you serve primarily (~ 50% or more) American Indian and/or Alaska Native patients in an outpatient care setting?

Yes

No

## Demographics

2. Job title/role

3. How many years have you worked at the current outpatient clinic/practice? (Please enter a number only; e.g., 6 years, 6 months = 6.5)

4. Are you American Indian or Alaska Native yourself?

Yes

No

5. What types of services does your outpatient clinic/practice provide? (Check all that apply.)

Primary care

Specialty clinic/services

Behavioral health services

Referrals

Other (please specify)

6. What state is your office located in?

7. Do you serve a primarily rural or urban population?

Rural

Urban

Suburban

Other (please specify)

8. Is your clinic/practice managed by:

- Indian Health Services
- Tribe(s)
- Non-native entity
- Other (please specify)

9. What populations are served by your clinic/practice?

- American Indian and Alaska Native only
- American Indian and Alaska Native AND non-Native populations
- Other, please describe

10. Does your clinic/practice primarily serve one tribe or multiple?

- One tribe
- Multiple tribes

11. Approximately what percentage of the patients you see are 60 years and older?

## Experience with Elder Abuse and Mistreatment

12. Have you ever seen an elder patient in your clinical practice who has potentially experienced any of the following types of abuse (Select all that apply):

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect
- Financial abuse or exploitation
- None, never had a patient suspected of elder abuse
- Other (please specify)

13. What types of elder abuse are most prevalent in your clinical practice? (Select all that apply.)

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect
- Financial abuse
- None is more prevalent than the others
- Other (please specify)

14. To what extent do you agree or disagree with this statement:

***Outpatient providers are capable of identifying all different types of elder abuse?***

Strongly Disagree

Neutral

Strongly Agree



## Experience with Elder Abuse and Mistreatment: Mandatory Reporting

20. Does your state require mandatory reporting in suspected cases of elder abuse?

- Yes
- No
- Don't know
- Other, please describe

21. Does your tribe require mandatory reporting in suspected cases of elder abuse?

- Yes
- No
- Don't know
- Other, please describe

22. Do you have any comments on mandatory reporting of elder abuse?

\* 23. Does your clinic/practice routinely screen for elder abuse?

- Yes
- No

Experience with Elder Abuse and Mistreatment: Screening

24. What screening tool do you use?

Experience with Elder Abuse and Mistreatment: Protocol

\* 25. Does your clinic / practice have a standard protocol or process for handling suspected cases of elder abuse?

- Yes
- No
- Don't know

Experience with Elder Abuse and Mistreatment: Protocol

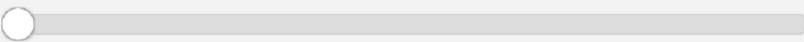
26. Please describe the protocol, process, or tools for handling elder abuse in your clinic/practice

Experience with Elder Abuse and Mistreatment

27. To what extent do you agree or disagree with the following statement:

***All clinical providers in outpatient care settings should play a role in screening for elder abuse and mistreatment.***

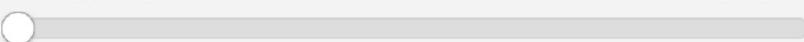
Strongly disagree                      Neutral                      Strongly agree



28. To what extent do you agree or disagree with the following statement:

***Personally, I consider myself to be knowledgeable about best practices for identifying cases of suspected elder mistreatment.***

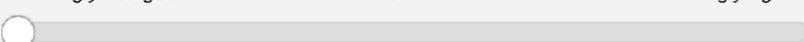
Strongly disagree                      Neutral                      Strongly agree



29. To what extent do you agree or disagree with the following statement:

***Personally, I consider myself to be knowledgeable about best practices for managing cases of suspected elder mistreatment.***

Strongly disagree                      Neutral                      Strongly agree



30. What do you believe are the **top 3 barriers** to screening for elder abuse in your clinic/practice?

- Lack of standards for talking with patients about potential abuse
- Variation in definitions of abuse
- Significant diversity in the types and manifestations of elder abuse
- Difficulty distinguishing mistreatment from accidental trauma, illness, or quality of care issues
- Lack of universal screening tools for elder abuse
- Wide range of risk factors
- Confusing or no guidance about who to screen
- Confusing or no guidance on how to respond if abuse is identified
- Lack of community services for elders identified as abused or mistreated
- Limited or poor follow-up when cases are reported
- Personal discomfort / uncomfortable (for provider) talking about abuse
- Time constraints in the clinical setting
- Variation in state or tribal laws regarding mandatory reporting
- Presence or reliance on family members or caregivers in the assessment and treatment process
- Communication difficulties with older adults (hearing, cognitive impairment, etc.)
- Other (please specify)

31. Are there any other barriers not identified above?

Experience with Elder Abuse and Mistreatment: Best Practices and Training

32. What resources, tools, information or support do you need to feel more comfortable managing older patients who you suspect or confirm have been abused?

33. Do you have examples of clinics, practices or health systems (including your own) that you feel employ best practices surrounding the screening and management of elder abuse?

34. Do you feel you have adequate training in elder mistreatment detection, management and reporting?

- Yes  
 No

\* 35. Would you like to receive training in elder mistreatment, detection, management and reporting?

- Yes  
 No

Experience with Elder Abuse and Mistreatment: Best Practices and Training

36. What would you like the training to include?

## Cultural Beliefs and Practices

37. Do you feel as if the tribal community and community members you serve are **more acculturated** (more assimilated; identify with mainstream society) or more **traditional** (strong cultural identity)?

- Assimilated (strongly identifies with mainstream)
- Bicultural (identifies with both native and mainstream cultures)
- Traditional (strongly identifies with native cultures)
- I don't know
- Other (please specify)

38. To what extent do you believe community acculturation (more assimilated in to mainstream) has an effect on the prevalence of elder abuse?

Strongly disagree                      Neutral                      Strongly agree

39. To what extent do you believe community traditionalism has an effect on the prevalence of elder abuse?

Strongly disagree                      Neutral                      Strongly agree

40. If acculturation or traditionalism have an effect on the prevalence of elder abuse, please discuss how:

41. To what extent do you believe differences in acculturation between caregivers and elders increase risk of abuse?

Strongly disagree                      Neutral                      Strongly agree

42. There are many factors that can play a role in or contribute to elder abuse? What do you think are the most significant factors in the Native community your clinic serves?

43. How do you think the local tribal community/communities perceives the issue of elder abuse?

## Community Resources and Gaps

44. Do you feel like there are adequate resources in the community you serve to address the needs of elder abuse victims?

- Yes
- No
- I don't know
- Other (please specify)

45. Have you ever made a referral to any of the following agencies or entities for suspected cases of elder abuse? Select all agencies or entities to whom you have made referrals:

- Adult protective services
- Law enforcement
- Behavioral health
- Domestic violence shelter
- Health care licensing (for abuse perpetrated by health providers)
- Local council or area agency on aging
- Other, please describe

46. Comments or concerns about referrals you have made:

47. To what extent do you agree or disagree with the following statement: I know who to contact for reporting elder mistreatment.

Strongly disagree

Neutral

Strongly agree

