Elder Abuse

XinQi Dong
Editor

Elder Abuse

Research, Practice and Policy

Editor
XinQi Dong
Rush Institute for Healthy Aging
Rush University Medical Center
Chicago, IL
USA

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Foreword

I often frame conversations about elder abuse with three questions: Do you know any older adults who are abused? Do you know who they are? Do you know what they need from you? The answer to the first questions is, yes—you always do. For many years, elder abuse has been a silent issue. Many older adults are afraid or embarrassed to bring their issues into the light. However, in recent decades, we have made tremendous strides on advancing recognition of interpersonal violence as a major public health concern, but not enough has been done to shed a light on abuse and neglect in older age. Despite the fact that elder abuse is less visible than other forms of abuse, we know that at least one in 10 adults over the age of 60 has experienced violence, neglect, or financial exploitation—usually by someone they know and trust—in the past month. Elder abuse is a public health and human rights problem of global concern. It erodes the humanity in all of us as we strive to reach old age and remain independent, with our dignity in place.

I am passionate about the issue of violence against older adults and their mistreatment. As Assistant Secretary for Aging in the U.S. Department of Health and Human Services, I have dedicated my leadership to forging and strengthening partnerships across federal government, with community partners and other expert stakeholders, to raise the visibility of elder abuse as a public health issue impacting, and impacted by, multiple areas of public policy.

The multifaceted nature of elder abuse has contributed, in part, to our insufficient knowledge of its prevalence and how best to respond. We need more comprehensive literature aimed at a broad constituency to address it. *Elder Abuse: Research, Practice and Policy* is an important step forward in the continuing effort to educate and challenge those in and out of the field of aging. By learning comprehensively where we are, we can begin to see where we need to be.

Part of the challenge that books such as this pose for all of us in the field is: How do we get the message out? This book may help professionals and policymakers alike to help reframe the public discussion and understanding about older adults; how they age, the challenges of abuse, and what do we need to learn from research to create effective policy. Aging experts already know that success in understanding and addressing elder abuse requires a multidisciplinary approach and success will only be measured through coordinated research and practice. We still have so much to learn.

As an advocate, I am heartened to see movement in the areas of aging policy, new interest in research and constant review in innovation in practice. This book will help raise questions, expand thinking of those in the field, and inspire additional research. In addition, I hope it spurs thinking about best approaches to addressing prevention and intervention for elder abuse. This book will shine a new light on the issues surrounding elder abuse, and thus the issue will find a new audience. What was once a very small field is expanding to include new minds and hearts. There are new voices in the field and they are invigorating it.

Learning what we know is essential to planning the next steps. This book is part of a foundation with others for us to think about where we are and where we need to go to bring the field of aging research, practice and policy in line with the very complex and growing needs of a demographic expanding by thousands every day.

We are mindful that our work has merely begun. The field of elder abuse remains far behind the fields of child abuse and intimate partner violence, but it is becoming more prominent. As we learn to articulate the needs of older victims and survivors, they will also be a voice to guide us. They will teach us what to research, how to practice and what policies are needed for a good, long life free from abuse.

With this book we have an important contribution to the field. With each new book focusing on elder abuse, the field grows in new and important ways. I am encouraged that this volume will find itself a catalyst for others, whose work we have yet to see.

Kathy Greenlee
Assistant Secretary for Aging
Administrator, Administration for Community Living
U.S. Department of Health and Human Services

Prologue

Elder abuse (EA) is a prevalent, identifiable, fatal and costly public health issue that affects populations living in both communities and institutional settings of all sociodemographic and socioeconomic strata. The problem is particularly disturbing given the estimated global population growth of people aged 65 from 2010 to 2050, is predicted to triple and reach 1.5 billion individuals or 16% of the world's population [35]. The field of elder justice has to take a vertical leap to understand and protect this vulnerable population through coordinated efforts across community, city/state, federal, and international organizations. This comprehensive volume aims to objectively provide the state of the science for the past, present, and future for the field of elder justice through systematic evaluations of research, practice, and policy.

Research

Defining EA

Definitions and typology of EA vary across nations, states, disciplines, organizations, and studies. For example, the World Health Organization, the National Center on Elder Abuse (NCEA), and the National Research Council (NRC) all define EA divergently regarding the terminology, subtypes, and case identification criteria [18, 25, 34]. Such methodological inconsistency has limited the ability of current research to systematically assess prevalence, incidence, correlates and severity of EA, further prohibiting translating the knowledge into intervention strategies and policy development. Recent studies showed great variations of EA prevalence estimates (e.g., 1.0–47.3% in North and South America; 0.1–61.1% in Europe; 0.22 per 1000–62% in Asia; 0.6, 30, and 64.3% in Africa) [4, 11, 36], which might be explained by the large methodological variations across studies. However, researchers should also be cautious of applying general definitions of EA to more specific populations because contextual factors (institutional, environmental, cultural, etc.) play essential roles in determining perceptions of acceptable and unacceptable behavior toward older adults. This might significantly influence the valuation of prevalence, incidence, severity, associated factors, and consequences, and efficacy of practices of EA. Hence, a balanced perspective asserting the importance of both a broad definition and specific definitions for particular populations and settings may better project directions for future actions on defining EA and subtypes. Additionally, while a variety of definitions for EA might still be used by different disciplines, the scholars should be more explicit concerning the terminology, typology, derivation of definitions, and process of refining definitions (if any) for EA and subtypes in their future publications.

Population Research

Large-scale representative longitudinal studies in diverse community and institutional settings are necessary to adequately examine the incidence of EA and subtypes. In the U.S., few studies have reached national representativeness, nor engaged longitudinal designs to detect the true incidence of EA through longitudinal studies [6, 9, 17]. While there exists no such national representative study and given the time and resources restraints, researchers and

funders might consider integrate EA incidence measurement questions into the existing representative longitudinal aging studies in diverse settings [10].

It is also crucial to improving the validity, reliability, cultural sensitivity, appropriateness, and ability to capture multilevel factors of the screening instruments in population studies. Older persons might be presented with particular challenges to disclosing abusive events due to physical and cognitive impairment, medical conditions, recognition difficulties, and dependence on the perpetrators. Minority and marginalized older populations might have more cultural, linguistic, and literacy barriers in detection, reporting, and help-seeking behaviors. Hence, screening instruments should be rigorously tested and tailored to be appropriate considering individual traits, cultures, language, and literacy capacity. Second, best modes of administrating screening tools (e.g., phone, in person, computer-based) to certain populations should be examined. Third, despite victims and perpetrators traits, studies should design instruments with abilities to solicit contextual factors from multiple types of informants.

Risk Factors and Consequences of EA

Rigorously designed longitudinal studies measuring the incidence of EA and subtypes in both victims and potential perpetrators can enhance the knowledge of EA risk/protective factors, adverse health outcomes, and the effect size of these associations. Current knowledge remains rudimentary pertaining important sociodemographic and socioeconomic characteristics of EA victims as no consistent trend of associations has been found between these potential risk factors and abusive events [11, 15, 20]. However, several other characteristics of victims, perpetrators, social relationships, and environments have been linked to greater likelihood of different subtypes of EA including victim's cognitive impairment, physical function impairment, psychological distress; perpetrator's heavy burden as caregivers and psychological/psychiatric illness; poor social relationships; less supportive environments; and previous traumatic event exposure [1, 11, 17, 20, 22].

With respect to the consequences, EA has been linked to increased risk of morbidity and premature mortality, physical injuries, functional impairment and dependency, declined health status, psychological distress, and social isolation [8, 13, 14]. Furthermore, such adverse physical and psychological outcomes may lead to increased medical costs in the forms of healthcare utilization and nursing home placement [13, 14, 17]. Assessment of economic impact of EA and subtypes vary greatly across investigations—$2.9 billion estimated by MetLife Mature Market Institute (2011) and $36 billion projected by another organization (TrueLink) for the annual cost of elder financial abuse [30].

Understanding causal relationships and strengths between elder abuse with proximal and distal outcomes are vital for developing prevention and intervention strategies and measuring the impacts and magnitude of EA. To date, many EA studies are cross-sectional, making it impossible to draw the cause–effect inference between EA and potential risk/preventive factors and consequences. Sir Austin Bradford Hill's [19] groundbreaking criteria have shed light on examining causal associations between exposure variables and health outcomes in such longitudinal studies. The associated factors of EA should all be rigorously evaluated through longitudinal studies following the Branford Hill's Criteria. This also applies to the examination of the potential consequences of EA. The criteria (***strength, consistency, specificity, temporality, dose–response, plausibility, coherence, experimental evidence, and analogy***) can provide evidence for causality between a cause (e.g., victim's cognitive impairment) and effect (e.g., abusive events). Additionally, longitudinal studies may adopt theoretical frameworks to guide study design and situate abuse events in ecological contexts, accumulating life-course experiences, and intergenerational and family relationships.

Intervention

A number of proposed intervention and prevention strategies exist in public, community, clinical and policy arenas, but none has sufficient evidence for the long-term effectiveness on reducing occurrence or severity of EA. The strategies include public awareness campaigns,

advocacy, clinical screening, educational programs for health professionals, counseling sessions, support groups, case management, and state statutes mandating abuse report to law enforcement officials or social services [11, 17, 26]. Each of the strategies ought to be tested rigorously for empirical evidence suggesting its intentional benefits and potential harms, since EA related practices may lead to adverse outcomes to the older adults [12]. A randomized clinical trial (RCT) by MacMillan and colleagues [23] shows insufficient evidence of both effectiveness and harm of IPV screening tools for a large cohort of women (n = 6743) in healthcare setting, which is nevertheless recommended by the U.S. Preventive Services Task Force. More evaluation research as such is needed to examine best practices for EA prevention and intervention.

Future EA intervention studies need improvements in several aspects. Findings of the Ploeg and colleagues [26] study reviewing current intervention studies of EA suggested common methodological limitations as follow: (a) lack of experimental designs; (b) poor presentation of research process such as randomization, assignment concealment, blinding researchers, and data analysis; (c) unrepresentative samples; (d) lack of psychometric outcome measures; (e) follow-up rates lower than 80%; (f) lack of adjustment of baseline differences between groups; (g) possible bias occurred in data collection by caseworkers.

Adherence to high ethical standards should be emphasized in future large-scale experimental designs and RCTs related to abuse, exploitation, and neglect. The investigators may follow the WHO recommendations for research in domestic violence against women to (a) paramount the safety of respondents and the research team; (b) hold participants' information and response to strict confidentiality; (c) carefully select, train, and support the research team; (d) design actions aimed at reducing any distress caused to the participants; (e) train fieldworkers to refer participants to available sources of assistance and support; (f) ensure findings are properly interpreted and used to advance policy and intervention development [27]. Also, researchers are well situated to leverage advocacy efforts by underscoring the importance of empirical evidence supporting effective intervention strategies in languages of stakeholders and the public, so that society is informed of where to best invest limited public resources.

Culture

Investigating cultural variations and their profound impact on beliefs, perceptions, and social norms should be prioritized in research since older adults from diverse racial/ethnic, gender, and sexual minority groups might be more susceptible to abuse, neglect, and exploitation. The pronounced demographic shift globally calls for extensive investigations to better understand EA surrounding prevalence, incidence in various populations, cultural variations in terms of the definitions, measurements, risk/preventive factors, and consequences, as well as culturally appropriate and effective intervention and prevention strategies. A few recent studies have enhanced the knowledge in diverse cultures such as African Americans, Latinos, and Chinese. For example, findings of the PINE study [16] surveying 3159 community-dwelling Chinese older adults in Chicago found a prevalence of 15.0% for abuse, and explored important correlates, potential risk factors, and consequences. Of note, it investigated possible cultural determinants for EA, such as the traditional practice of filial piety and its potential to influence the occurrence, perception, and response of abuse. The study also examined other possible confounding characteristics of U.S. minority populations, including acculturation, intergenerational differences, and the immigrant experience.

Innovative strategies should be used to better address EA in minority communities. The long-lasting and discriminatory system-level exclusion of the minorities, resources disparities, and cultural and linguistic barriers make it difficult to establish rapport between the communities and the research field. Community-Based Participatory Research (CBPR) has proved to be able to generate community-derived solutions that are culturally applicable throughout research initiation, implementation, results dissemination, and sustained development. Researchers have demonstrated that community health workers (CHWs) could boost

community empowerment in CBPR intervention studies by translating intervention strategies designed by the academic institution into community practice and service [29]. The PINE study [10,15, 16] exemplified the success of the CBPR model employing bi-cultural and multilingual CHWs to untangle complicated cultural and linguistic barriers within large and diverse immigrant communities. The study also benefits from increased community engagement and commitment brought by the research-to-community shift of ownership, power, and resources by engaging CHWs. Furthermore, for complex research problems as culture-specific EA, it is valuable to combine quantitative and qualitative methods because their complimentary nature can result in a broader and deeper understanding of EA and its cultural context.

Interdisciplinary and Translational Research

Given the lack of empirical evidence for effective practices for EA, the merits of conducting multidirectional research from other disciplines is apparent. Researchers may be able to adapt screening measures and interventions that have proved promising within the areas of child abuse, youth violence, and IPV and test their efficacy for addressing EA. Several promising interventions worth examining are brief clinical interventions, bystander training, income supports, and environment modifications [32].

Many have recognized that a translational research framework might help fields including EA to integrate and translate multidisciplinary research findings (e.g., biomedical science, psychology, neuroscience, etiology, behavioral science, epidemiology, and political science) into improvements in public well being and health. Based on initial discussions, Rubio and colleagues [28] developed a translational model of multidirectional continuum, in which research investments and findings interact between basic research, patient-oriented research, and population-based research (e.g., epidemiology, social behavioral sciences, public health research). The model has thrown lights on promising translational research opportunities and partnerships among experts in the EA field and other disciplines. More support should be given to these areas of collaborative research such as biomarker and biology mechanism (e.g., relationship between vitamin D deficiency and EA), behavioral science techniques (e.g., motivational interview), neuroscience (e.g., human brains' influence on financial decision-making and exploitation), and technologies.

Practice

While rigorous and systematic evidence-based prevention and intervention strategies are not available, practical actions and systematic improvements can take place in communities, healthcare settings, and institutional facilities, where local organizations, staffs, and key personnel might be well situated to offer immediate response and protection to older adults susceptible to abuse.

Education and Training

We should leverage efforts to support worldwide and nationwide educational and training activities relating to EA for both workforce and the public. Research shows a lack of professional and public awareness of the prevalence and severity of abuse in community, institutional, and healthcare settings. Key workforce who are exposed regularly to older people have insufficient awareness, knowledge, skills, and confidence dealing with EA, and are unfamiliar with related case identification and report procedures, legislation, and referral agencies when confronted with suspected abuse occurrence [5, 21]. Educational activities should be tailored and incorporated into training of different personnel ranging from healthcare students and professionals, law enforcement, social services, community organization staffs, volunteers, and frontline health workers.

Community Settings

To date, 64.9 million older adults in the U.S. are living in a community setting. Adult Protective Services (APS) caseworkers are the first responders for abuse case report in each state, providing services including receiving reports of abuse, investigating cases, case planning, and service monitoring and evaluation [3]. Meanwhile, the National Aging Network, a government-funded services network, provides community-level resource and technical assistance for victims of EA. Within the network, 629 area agencies on aging, nearly 20,000 service providers, 244 tribal organizations, and 2 native Hawaiian organizations representing 400 Tribes serve communities with services that include, but not limited to information and referral, counseling, nutrition, social engagement and entertainment activities, legal services, personal/home care, instrumental service (e.g., transportation), and specific services for native populations [2].

Previous investigations [9, 17, 31] show major challenges confronted by the APS programs, which are (a) increasing numbers and complexity of cases that lead to heavier caseloads for staffs; (b) unstable and insufficient funding sources supporting APS programs and services; (c) the noted lack of empirical evidence suggesting best solutions for resolving EA; (d) lack of indispensable training and capacity to deal with complicated abusive cases; (e) lack of multidisciplinary collaborations among APS and other partners such as the medical, legal, criminal and financial fields to optimize the effects of the programs and services; (f) the varied data collection systems of the APS across states has resulted in missing opportunities for staff to use valid information from previous programming and intervening experience. In regard to APS practices and other federal-funded agencies addressing EA in communities, funding, personnel training and support, unified data system, and inter-agency collaborations should be given or developed to address these gaps in the ability to investigate and protect older adults from EA.

Institutional Settings

In addition to older adults living in community settings, abuse, neglect, and exploitation in long-term care settings are understudied and warrant further investigation. The Long-Term Care Ombudsman Program (LTCOP) resolves complaints, protects rights, and advocates change of policies and practice for long-term care residents. In many states, the APS caseworkers also address EA in institutional settings. Similar to APS, the LTCOP also face insufficient financial resources, and the National Association of State Long-Term Care Ombudsman Programs [33] has synthesized recommendations for future LTCOP activities such as to strengthen the autonomy of the ombudsman program to help individual residents, and to improve national reporting system that incorporate the rich information obtained from LTCOP data. More importantly, staff who care for long-term facility residents are likely to deal with more adverse health or medical conditions and declined function, such as chronic disease, dementia, and mental diseases. This urges efforts for more comprehensive education, training, supervision, support, and assessment for the LTCOP staff in terms of skills, values, and temperament.

Healthcare Settings

Professionals in healthcare settings (e.g., nurses, physicians, social workers, psychologists, discharge planners) can play important roles in detecting vulnerabilities and intervening suspected EA cases due to their regular interactions with older patients. Priority should be set to pursue evidence for the strategies in healthcare settings, as they have not been tested adequately through empirical research. But immediate field response and actions should be taken to avoid leaving tens of thousands of at-risk older adults unprotected. More guidance and support ought to be available for the professionals, and they may consider several brief screeners (e.g., HS-EAST, VASS, and EASI recommended by CMS) [12] and stepwise

procedures for dealing with EA cases in healthcare settings developed by other experienced scholars.

Since most states in the U.S. mandate healthcare professionals to report EA cases to the APS caseworkers, the collaborations between the two parties might face specific challenges such as poor communications and health professionals' incompliance of reporting requirement. To optimize the efforts in healthcare settings to address EA, effective coordination and communication between professionals and APS, and culturally competent approaches and practices suit each healthcare facility might be appropriate [7].

Policy

Drafting and implementing policies must serve their purposes for protecting the rights of millions of older adults. Although steps have been taken in the legal system to protect the human rights of older adults globally (e.g., the International Plan of Action on Aging and the International Covenant on Economic, Social, and Cultural Rights), there is a lack of strength in policies to implement and enforce them at international and domestic levels [24]. Miller [24] called for a solution to developing a comprehensive and binding international treaty to set a standard of protection for the older people, by which, national governments would be accountable for protecting the human rights, addressing specific needs, ensuring safety and care quality in nursing homes and other institutional facilities, and supporting better EA public and professional education.

In the U.S., there are several major federal statutes addressing elder justice issues including the Older Americans Act (OAA), the Elder Justice Act (EJA) portion of the Affordable Care Act (ACA), the Violence against Women Act (VAWA), the Public Health Service Act, and the Social Security Act. Meanwhile, a number of federal agencies have been playing essential roles in protecting older adults from abuse such as the National Institutes of Health (NIH), the Center for Disease Control and Prevention (CDC), the Administration on Community Living (ACL), Department of Justice Civic Division, National Institute of Justice, Office of Victims of Crimes, and the Office on Violence Against Women [9, 17].

However, support for national activities protecting rights of older Americans have been scattered across the country, and there is a need for stronger federal leadership to prioritize EA in research, public advocacy, policy development, practice, and education. Second, there is insufficient coordination of these federal level agencies, legislation, and other efforts to provide most effective protection and treatment for older adults who are at risk of abuse, neglect, and exploitation [9, 17]. Most importantly, continuous funding support for the legislations is essential for implementation and service delivery. Federal spending on activities for EA ($11.9 million) was 54 times less than that for violence against women ($649 million) and 588 times less than that for child abuse ($7 billion) [11].

Conclusion

The world's rapidly growing population urges the needs for leveraged efforts and funding resources from global investigators and stakeholders within the realms of research, intervention, practice, education, and policy. Nationally representative longitudinal research is needed to better define the incidence, risk/protective factors, and consequences of EA in diverse racial/ethnic, gender, and sexual minority populations in each region globally, and methodological consensus has to be reached in related studies to generate systematic research results and knowledge. While we have incomplete empirical evidence for best intervention and prevention strategies to address EA, coordinated efforts are needed from governments, policymakers, global and national organizations, community stakeholders, frontline workforce, healthcare professionals, and law enforcement institutions to provide linguistically/culturally appropriate response for elder abuse, neglect, and exploitation and protect the rights of this extremely vulnerable population. As the editor for this comprehensive volume, I am forever

indebted to the perspicacious contributors of this textbook. Their dedication, commitment, knowledge, and sage wisdom will continue to inspire the field of elder abuse and pave the road for the future global generations of researchers, educators, advocates, practitioners, and policymakers.

Chicago, IL, USA XinQi Dong

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Contributors

Ron Acierno College of Nursing, Medical University of South Carolina, Charleston, SC, USA; Ralph H. Johnson Veterans Affairs Medical Center, Charleston, SC, USA

Georgia J. Anetzberger Department of Medicine, Case Western Reserve University, South Euclid, OH, USA

Sophia Autrey Centers for Medicare and Medicaid Services, Baltimore, MD, USA

Scott R. Beach University Center for Social and Urban Research, University of Pittsburgh, Pittsburgh, PA, USA

Avital Benson The John A. Hartford Foundation, New York, NY, USA

William F. Benson National Adult Protective Services Association, Health Benefits ABCs, Silver Spring, MD, USA

Robert B. Blancato Elder Justice Coalition, Washington, DC, USA

E-Shien Chang Rush Institute for Healthy Aging, Rush University Medical Center, Chicago, IL 60612, USA

Ruijia Chen Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Public Health, Cambridge, MA, USA

Kendon J. Conrad Department of Health Policy and Administration, University of Illinois at Chicago, Chicago, IL, USA

Loree Cook-Daniels FORGE, Inc, Milwaukee, WI, USA

Victoria L. Crabb Department of Epidemiology, University of Iowa College of Public Health, Iowa City, IA, USA

Jeanette Marie Daly Department of Family Medicine, University of Iowa Hospitals and Clinics, Iowa City, IA, USA

Margaret Davis Department of Psychiatry, VA Ann Arbor Health Care System/University of Michigan, Ann Arbor, MI, USA

Marguerite DeLiema Stanford Center on Longevity, Stanford University, Stanford, CA, USA

XinQi Dong Rush Institute for Healthy Aging, Rush University Medical Center, Chicago, IL, USA

Carmel B. Dyer Department of Internal Medicine, Division of Geriatric and Palliative Medicine, University of Texas Medical School, Houston, TX, USA; Texas Elder Abuse and Mistreatment Institute (TEAM), Houston, USA; Harris Health System, Houston, USA; UTHealth Consortium on Aging, Houston, USA

Gracy Fang Department of Social Work and Social Administration, University of Hong Kong, Hong Kong, Hong Kong

Terry Fulmer The John A. Hartford Foundation, New York, NY, USA

Jacqueline S. Gray Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, Grand Forks, ND, USA

Kathy Greenlee Assistant Secretary for Aging and Administrator, Administration for Community Living, U.S. Department of Health and Human Services, Washington, DC, USA

Jeffrey E. Hall Division of Violence Prevention, Centers for Disease Control and Prevention, Atlanta, GA, USA

Candace J. Heisler Heisler and Associates, San Bruno, CA, USA

Shelly L. Jackson Department of Psychiatry and Neurobehavioral Sciences, Institute of Law, Psychiatry and Public Policy, University of Virginia, Charlottesville, VA, USA

Marshall B. Kapp Center for Innovative Collaboration in Medicine and Law, Florida State University, Tallahassee, FL, USA

Brian W. Lindberg Elder Justice Coalition, Washington, DC, USA

Jane Lucas Quality Insights of Pennsylvania, King of Prussia, PA, USA

Andy Mao United States Department of Justice, Washington, DC, USA

Meaghan McMahon Washington, DC, USA

Tara L. McMullen Centers for Medicare and Medicaid Services, Baltimore, MD, USA

Kylie Meyer Leonard Davis School of Gerontology, Los Angeles, CA, USA

Charles P. Mouton Family and Community Medicine, School of Medicine, Meharry Medical College, Nashville, TN, USA

Carrie F. Mulford National Institute of Justice, Office of Justice Programs, United States Department of Justice, Washington, DC, USA

Corey Nichols-Hadeed Department of Psychiatry, University of Rochester Medical Center, Rochester, NY, USA

Nora OBrien-Suric The John A. Hartford Foundation, New York, NY, USA

James G. O'Brien Institute on Sustainable Health and Optimal Aging, Louisville, KY, USA

Elizabeth Podnieks Department of English, Ryerson University, Toronto, ON, Canada

María D. Pérez-Cárceles Department of Legal Medicine, Institute of Research into Aging, Biomedical Research Institute (IMIB-Arrixaca), Regional Campus of International Excellence "Campus Mare Nostrum", School of Medicine, University of Murcia, Murcia, Spain

Mary Joy Quinn San Francisco Superior Court San Francisco, California, USA

Carlos A. Reyes-Ortiz Division of Geriatric and Palliative Medicine, Department of Internal Medicine, University of Texas Medical School, Houston, TX, USA; Texas Elder Abuse and Mistreatment Institute (TEAM), Houston, USA; Harris Health System, Houston, USA; UTHealth Consortium on Aging, Houston, USA

Gary Rezek Quality Insights of Pennsylvania, King of Prussia, PA, USA

Karen A. Roberto Center for Gerontology, Virginia Polytechnic Institute and State University, Blacksburg, VA, USA

Susan K. Roepke-Buehler Behavioral Sciences and Medicine, Rush University Medical Center, Chicago, IL, USA

Elizabeth J. Santos Department of Psychiatry, University of Rochester Medical Center, Rochester, NY, USA

Margot J. Schofield Department of Psychology and Counselling, School of Psychology and Public Health, La Trobe University, Melbourne, VIC, Australia

Kimberly Schwartz Centers for Medicare and Medicaid Services, Baltimore, MD, USA

Jeannette Shrift Quality Insights of Pennsylvania, King of Prussia, PA, USA

Joseph Snyder Philadelphia Corporation for Aging, Philadelphia, PA, USA

Anita Somplasky Quality Insights of Pennsylvania, King of Prussia, PA, USA

Janet H. Southerland Oral and Maxillofacial Surgery, School of Dentistry, Meharry Medical College, Nashville, TN, USA

Karen Stein School of Public Policy and Administration, University of Delaware, Newark, DE, USA

Lori A. Stiegel American Bar Association Commission on Law and Aging, Washington, DC, USA

Pamela B. Teaster Center for Gerontology, Virginia Tech, Blacksburg, VA, USA

Cynthia Thomas Committee on National Statistics, National Academies of Sciences, Engineering and Medicine, Rockville, MD, USA

Robert B. Wallace Department of Epidemiology, The University of Iowa Center on Aging, Iowa City, IA, USA

Kathleen H. Wilber Leonard Davis School of Gerontology, Los Angeles, CA, USA

Joah L. Williams Department of Psychology, University of Missouri—Kansas City, Kansas City, MO, USA

Erica Wood American Bar Association Commission on Law and Aging, Columbia, DC, USA

Elsie Yan Department of Applied Social Sciences, Hong Kong Polytechnic University, Hong Kong, Hong Kong

Jeanine Yonashiro-Cho Leonard Davis School of Gerontology, Los Angeles, CA, USA