Sexual Violence in Later Life

A technical assistance guide for health care providers

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The U.S. Census Bureau estimates that by the year 2050, adults age 65 or older will account for 25% of the population (U.S. Census Bureau, 2008). National data suggests that three to five million older adults experience some form of abuse annually (Connolly, 2011). The National Center on Elder Abuse found that between one and two million Americans age 65 and older have been injured, exploited, or otherwise mistreated by someone on whom they depend (National Center on Elder Abuse, 2012).

Sexual violence in later life (a subcategory of older adult abuse) is neither well understood nor well identified in health care communities. Despite this, the potential for physical and emotional sequelae or aftereffects of sexual violence against older adults is significant.

Because it is more common for older adults to seek regular health care services, providers are in a unique position regarding effective identification and response to abuse (National Center on Elder Abuse, 2012). The short- and long-term health implications for patients, in combination with increased mortality rates, make recognizing and effectively responding to sexual violence against older adults an

important responsibility of all health care professionals. Collaboration with community-based sexual assault organizations and advocates is helpful in ensuring that health care professionals have the tools they need to identify and respond to sexual violence and to connect victims with supportive services.

The purpose of this technical assistance guide is to assist physicians, nurses, and other clinical health care providers in meeting their professional obligations in identifying and providing intervention and treatment to older victims of sexual violence. It includes introductory information, including definitions and a problem statement, as well as case scenarios. Additionally, it discusses issues relevant to healthcare providers, such as practice recommendations, provider responsibilities, gathering the patient history, examination, and evidence collection. Patient safety and reporting, documentation, and treatment considerations – including sample questions and discussions to have with patients – also are in the guide, as is an introduction to forming meaningful collaborations with professionals in the community.

Definitions

The National Committee for the Prevention of Elder Abuse defines older adult abuse as "any form of mistreatment that results in harm or loss to an older person" and includes physical abuse, sexual abuse, intimate partner violence, psychological abuse, financial abuse, neglect, and self-neglect (National Committee for the Prevention of Elder Abuse, n.d.). The U.S. Centers for Disease Control and Prevention (CDC) states that elder mistreatment is abuse or neglect of a person age 60 or older by a care provider or person in a relationship involving an expectation of trust (CDC, 2010). While the offender is most often someone the older adult knows, it also is possible that they are a stranger. Five major categories of abuse are recognized: physical, psychological

In Later Life

Q: Who is an "adult in later life," and what terms are appropriate to refer to individuals in this population?

A: Different agencies and individuals define "later life" – including at what age it begins – differently. This guide follows the Office on Violence Against Women in defining later life as beginning at age 50; however, many state statutes use 60 and 65.

This guide also uses a number of terms – such as adult in later life, older adult, and elder – in discussing individuals in this age group. We use these terms to capture the many ways in which older adults self-identify, as well as to reflect the terms commonly used in law and literature.

or emotional, sexual, neglect, and financial exploitation. Self-neglect also has been identified, but typically is not recognized as a form of abuse because it does not involve a perpetrator.

The CDC classifies sexual violence as any sexual act that is perpetrated against someone's will. The definition encompasses a range of offenses perpetrated against women and men, as outlined in the text box at right.

Sexual violence against older adults occurs in both domestic and institutional settings, and it involves older adults who do not or cannot consent. Often the sexual violence is committed without the consent of the person harmed due to cognitive or other impairments (National Sexual Violence Resource Center [NSVRC], n.d.). Because sexual violence involves both medical and legal arenas, it is important for health professionals to understand that not all sexually violent acts are considered illegal, despite their health implications. It is up to local, state, tribal, and federal criminal-justice professionals to determine what criminal charges may result from the acts reported.

It is important for providers to understand that jurisdictions and agencies have different definitions of "elder." The National Clearinghouse on Abuse in Later Life (NCALL) considers older victims to be age 50 years and above, while most state laws identify people as "elderly" beginning at either 60 or 65. It is the provider's responsibility to know how "elder" is defined at the local level. Health care providers serving older adults need an understanding of all forms of older-adult abuse because sexual abuse is often embedded in a pattern of multifaceted elder abuse, whether it occurs in domestic or institutional settings. This is particularly likely when the perpetrator has ongoing access to the victim (Ramsey-Klawsnik, 2010).

Sexual Violence Includes:

- A completed nonconsensual sex act (i.e., rape)
- An attempted nonconsensual sex act
- Abusive sexual contact (e.g., unwanted touching)
- Non-contact sexual violence (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment) (CDC, 2010)
- Sexually explicit photographing or touching when not associated with a defined nursing plan of care (Burgess, 2006)

While this guide specifically addresses sexual violence in later life, other forms of abuse such as intimate partner violence, physical abuse, neglect, and financial exploitation may co-occur. The potential for multiple forms of violence to occur at the same time makes it critical that providers have a fundamental understanding of older adult abuse in all its forms. When other forms of abuse are present or suspected, providers should explore the possibility of sexual violence as well.

Section Two

Problem statement

There is wide agreement among researchers that abuse of older adults is a large-scale problem that has been inadequately addressed in health care settings. A recent study estimating prevalence of abuse against persons age 60 and older living in the community found that one in 10 were the victims of emotional, physical, sexual, and financial abuse or neglect (Acierno et al., 2010). The New York State Elder Abuse Prevalence Study found a one-year incidence rate of 72 per 1,000 when all form of abuse were considered (Lachs & Berman, 2011). Despite the relatively high number of older adults being mistreated, sexual violence rates are low when compared with other types of abuse. Acierno et al. (2010) found a prevalence rate of 4.6% for emotional abuse, 1.6% for physical abuse, 0.6% for sexual violence and 5.1% for possible neglect. Of those who were sexually violated, only 15.5% reported to police.

Available statistics for cases of sexual violence in which older adults were victimized are believed to be serious underestimates, particularly for individuals who are vulnerable, frail, and/or dependent on outside care as a result of a physical or cognitive disability (Roberto & Teaster, 2005). At the time of this publication, prevalence and incidence data on sexual violence against adults in later life was not yet available.

As with sexual violence against younger people, a multitude of factors influence disclosure or reporting rates for older adults.

For example, in cases of sexual violence against older adults, it is common for intimate partners and family members to be identified as offenders. This likely is due in part to the fact that many older adults with health problems are cared for by family members at home. Dependence on and fear of losing family members, intermingled with concerns over personal safety, make it difficult for older adults to report. In one study of community-based older adult sexual violence cases, 81% of the offenders were care providers; 78% of those identified as family members, primarily sons and husbands (Ramsey-Klawsnik, 1991). In the National Elder Mistreatment Study, 52% of the respondents who reported sexual violence said they were violated by a family member, primarily spouses and partners; 85% of all victims studied did not report to

THE CDC ESTIMATES MEDICAL AND MENTAL HEALTH CARE OF NEARLY $4.1 BILLION FOR INTIMATE PARTNER RAPE, PHYSICAL ASSAULT AND STALKING.

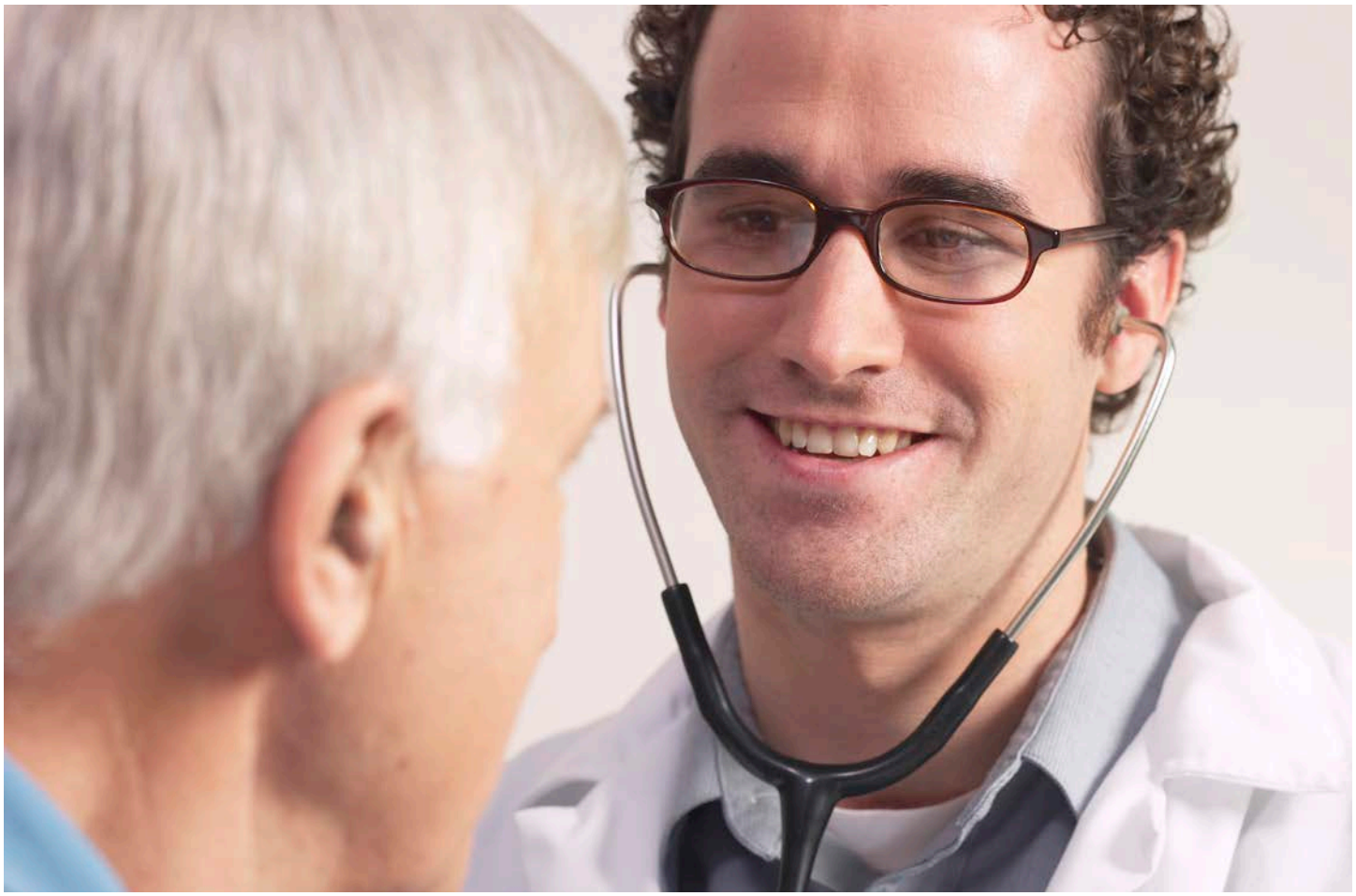
the police (Acierno, Hernande-Tejada, Muzzy, & Steve, 2009). Characteristics of family members that may raise suspicion for sexual abuse include the presence of mental illness, substance abuse, domineering personality traits, and a paternalistic view of wives as property (Ramsey-Klawsnik, 2003). Earlier research on elder abuse generally has shown that unemployment by the care provider, stress, fatigue, dissatisfaction, history of violence, psychological or physical impairment, poor impulse control, and a lack of knowledge of duties, resources, and/or services might also be factors (Allan, 2002).

A study of sexual violence in care facilities (such as nursing homes, group homes, psychiatric facilities, and assisted-living facilities) found that the two most common types of sexual violence offenders were employees responsible for the older adult's care (at 43%) and other residents (at 41%). Offenders ranged in age from 16 to 96, and the vast majority were male (Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008).

Physical or cognitive impairments, shame, fear, threats, and dependency on the care provider are all reasons that could prevent the older adult from reporting these offenses. Staff might dismiss the disclosure of abuse due to dementia; when the offender is another resident, staff also might feel like nothing can be done about it.

The health consequences of sexual violence for older adults are rarely teased out in the literature. However, the physical effects of sexual violence on women are well documented. Health problems include pain syndromes, gastrointestinal and gynecological disorders, eating disorders (particularly bulimia), and chronic headaches (Boyd, 2011). Sexual violence also may have significant mental health consequences such as depression, anxiety, substance abuse, post-traumatic stress, and suicidal ideation (Campbell, Dworkin, & Cabral, 2009).

Because sexual violence against older adults often takes place within the larger context of intimate partner violence, the older adult might experience increased physical injuries as a direct result of the violence, or any number of cardiovascular, gastrointestinal, or immune system complaints (Black et al., 2011). Recovery from injury and illness is more challenging with advanced age. In a study of abuse against older adults and mortality, those who reported abuse had a mortality rate 2.3 times higher than those who did not, whether or not the abuse was substantiated. However, the precise mechanism of the association between the abuse and mortality remains unclear (Dong et al., 2009).



Despite the strides made in recent decades to improve care of sexual assault victims in health settings, the development of identification and response techniques for older adults has lagged behind. Stigma and fear, dependency on the care provider, not wanting to leave their home, threats, emotional pain, and denial about the loved one responsible for the abuse keep many older adults from reporting. Others are unable to report because of a physical or cognitive impairment, or their disclosures are dismissed due to confusion or dementia. The first national study of sexual violence against older adults in care facilities identified shortcomings that include delayed reporting on the part of professionals; mean time between the violence and the report was six days. Researchers also found a lack of timely investigation by authorities (with a mean time of nearly 11 days between violence and the investigation), limited or insufficient involvement of law enforcement, delayed reporting of abusive staff in care facilities, and low prosecution rates. Furthermore, only 11% of older adults reporting assault received a medical evaluation (Ramsey-Klawsnik et al., 2008). For multiple reasons, sexual violence remains the least reported type of older adult abuse (Payne & Gainey, 2005).

It is difficult to the health care monetary burden specific to sexual violence in older adults due to the absence of data concerning sexual violence in this population. However, the CDC estimates medical and mental health care of nearly $4.1 billion for intimate partner rape, physical assault, and stalking (CDC, 2003).

CASE STUDY:
Nursing Home

Ms. M. is a 56-year-old female who has been living in a nursing home for 10 years. She has a history of schizophrenia, hypertension, chronic kidney disease, and has a urinary catheter in place at all times. She is sent to the local emergency department by ambulance after the nursing home staff discover blood clots in her genital area. Following irrigation of the foley catheter, it is clear the blood clots are not related to her urinary tract. Hemoccult stool is negative. Ms. M. is gesturing toward her genitalia, repeatedly saying, "he won't stop touching me down there."

Health care providers evaluate older adults in different practice settings. These settings might include nursing home and residential care centers, primary and private-practice settings, emergency care and home care settings. Regardless of setting, providers should remember that most older adults have the capacity to give informed consent regarding the care they receive. When there isn't capacity to give consent, it is important to obtain informed consent from a court-ordered substitute decision maker and/or follow the established policy within your facility.

The following case scenarios highlight indicators that should raise suspicion that sexual violence could be a concern. The recommendations below each case are not

all-inclusive, but they might help practitioners determine the best clinical course of action.

To provide the best possible care to Ms. M., a thorough history from the nursing home providers is essential. The historical information for this case should include, at minimum:

- When Ms. M. began reporting being touched
- When the staff first noted genital bleeding
- What hygiene/cleaning activities have occurred since (shower, bed, bath, wiping, etc.)
- Ms. M's level of independence with activities of daily living
- Whether or not there is a male staff person involved in Ms. M's care, and, if so, when was his last contact with Ms. M.

CASE STUDY: Independent-Living Facility

Mr. R. is a 68-year-old male receiving home care for a stroke he sustained four months ago. His 46-year-old son assists him with all of his activities of daily living. Visiting nurses come once per week. When the nurse arrived this week, Mr. R. had soiled himself. While giving him a bath, the nurse noted pinpoint bruises on the head of Mr. R.'s penis and a spot of blood on his underpants.

Typically, the visiting nurse can identify the patient's usual cognitive ability, which often can assist other providers with whom the patient might need to interact. In this scenario, the following considerations should be given when gathering the patient's history:

- The patient history must be obtained from the patient without the patient's son or any other party present to maintain privacy and confidentiality
- The history will need to include direct questions about the bruises and blood, as well as questions assessing for possible sexual victimization
- Consideration should be given to making sure the patient is offered a medical forensic examination with evidence collection
- If disclosure of sexual victimization occurs, ensure introduction to sexual assault advocacy services
- Plan for a discharge that includes addressing the safety of the patient and does not discharge the patient into the immediate or future care of the suspected perpetrator

CASE STUDY: Nursing Home

Mrs. V. is an 82-year-old resident of a local nursing home. She is transported to the emergency department by ambulance for new onset dysphasia (slurred speech) in the past 12 hours.

On exam, a blue bruise is noted below her chin and another behind her left ear, as well as a red, linear scratch to the right side of her neck. When the emergency department took report, no mention of injury was given.

When asked by emergency department staff how she got the injuries, Mrs. V. said the man who took care of her last night choked her.

CASE STUDY: Independent-Living Facility

Mrs. S. is 72 and lives in an assisted-living facility. She has mild dementia and is losing her sight as a result of diabetes. Mrs. S.'s daughter visits her monthly.

During her daughter's visit today, Mrs. S. told her that a male nurse came into her room during the night to give her medication, but he also had sex with her.

Her daughter immediately reported this to the nursing staff despite her mother's concerns that the offending nurse would be angry with her for telling.

Strangulation in a living patient — with or without symptoms — warrants a thorough medical evaluation because of the immediate and delayed risk of death (Anscombe & Knight, 1996; Hawley, McClane, & Strack, 2001). Strangulation commonly occurs with intimate partner violence (Shields, Corey, Weakley-Jones, & Stewart, 2010) and sexual violence. Even without a disclosure of strangulation, unexplained injury to the neck should prompt direct questions about possible strangulation from health care staff, particularly when there are accompanying stroke symptoms.

Offering a medical forensic examination with evidence collection is essential. Practitioners also are required by law to make a report of suspected older adult abuse to appropriate state officials. These may include Adult Protective Services (APS), law enforcement, and/or the health department that licenses care facilities (particularly if there is a possibility facility staff may be involved). Providers need to know which agency must receive the report and under what circumstances they must comply with mandatory-reporting requirements.

CASE STUDY: INDEPENDENT-LIVING FACILITY

Mrs. B. is 60 years old. She has been married for 39 years and has three grown children. She is receiving temporary home-care assistance for her new colostomy. Her daughter is visiting and speaks to her mother's nurse about her mom seeming depressed. With her daughter's prompting, Mrs. B. tells the nurse about how controlling her husband is and that he frequently forces her to have sex when she doesn't want to, even right after her surgery.

Given the disclosure, the nurse should:

- Offer emotional support (For tips on responding to disclosures, please check out http://www.nsvrc.org/sites/default/files/publications_SVlaterlife_Guide.pdf)
- Determine if the patient knows when her husband will return
- Determine if the patient has given thought to leaving the relationship or reporting the abuse to authorities
- Discuss with the patient the health implications of an abusive relationship
- Offer the patient the option of having a medical forensic examination
- Assist the patient in safely (away from her husband) accessing information with a local sexual assault service provider regarding available services and options, either via phone or in-person
- Assist the patient and her daughter in creating a safety plan if the patient opts to remain in the home

Section Four

Practice Recommendations

Trauma occurs when a person's physical or psychological integrity is threatened by an outside event, such as a car accident, sexual assault, or terrorist attack. The individual's internal or external resources are inadequate to cope with the external threat (Van der Kolk, 1989). In addition, the effects of trauma are cumulative. The greater the exposure to different types of trauma, the more complex the symptoms are (Briere, Kaltman, & Green, 2008). When caring for older adults who may have experienced sexual violence, it is important to recognize and consider the possibility of significant cumulative trauma.

Trauma-Informed Service Delivery

Available research on trauma's short- and long-term impacts on health demonstrates the critical importance of a trauma-informed care delivery system. Trauma can affect both the manner in which a patient approaches a provider, as well as the way a provider approaches a patient.

Trauma-informed care refers to recognition of the pervasiveness of trauma and a commitment to identify and address it early whenever

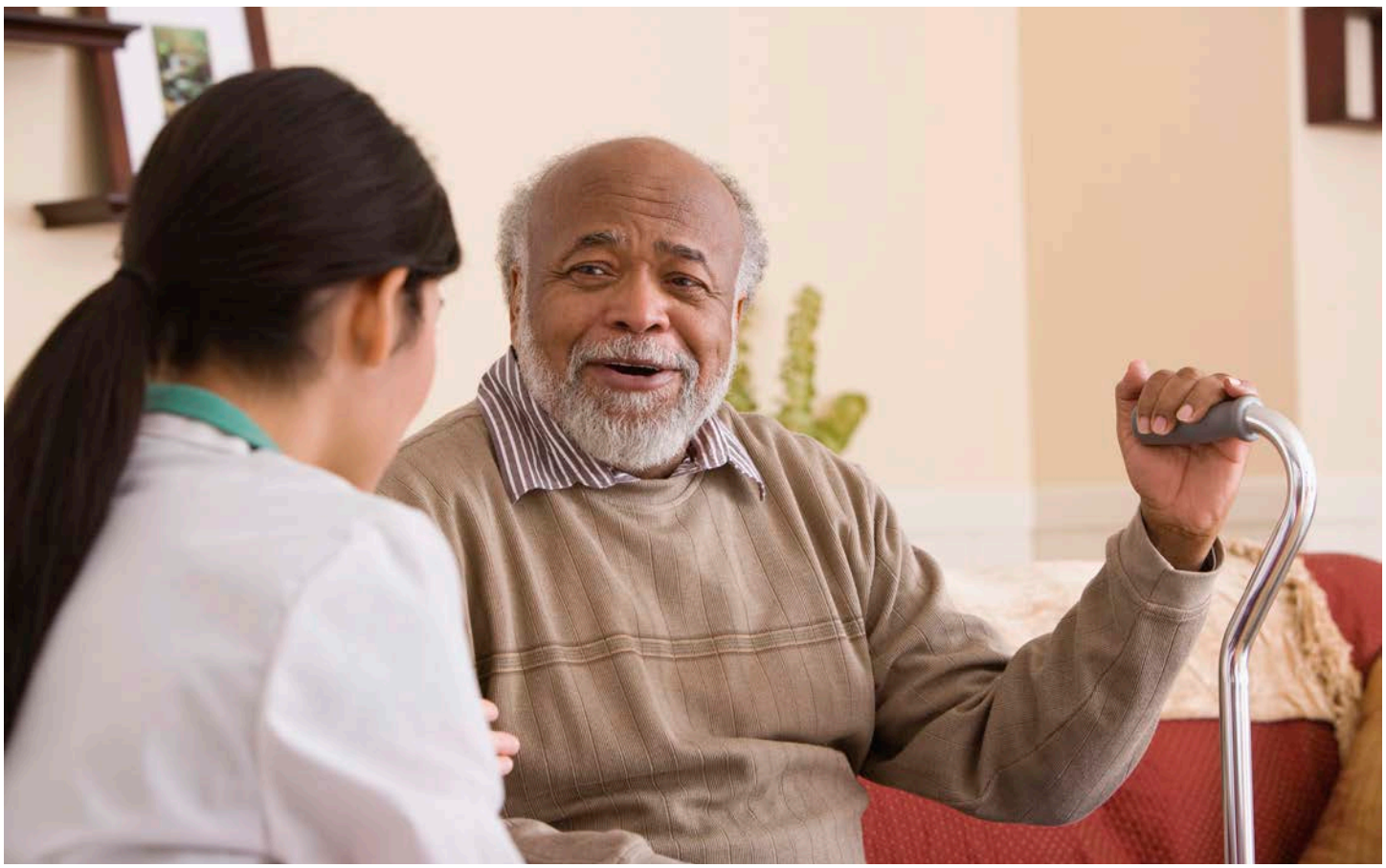
Minimizing further trauma

LISTEN	Often, health care providers are in such a rush that the perception of the patient is that the provider does not care about what happened to them. The patient might also feel like they are burdening the provider by telling his or her story. Taking a few minutes to sit face-to-face with patients and let them know that they are a priority can affirm that someone cares.
AVOID VICTIM-BLAMING	There are few things more traumatizing than having loved ones or health care providers say or do something that lays the blame for the sexual violence at the feet of the victim. "Why did you do that?" "What were you thinking?" "Why didn't you say something?" Statements such as these suggest the patient could have and should have prevented the sexual violence. The offender is no longer responsible, but the victim is. Compounding the shame a victim may already be experiencing impedes their recovery.
HOLD THE OFFENDER ACCOUNTABLE	Simple statements by providers that hold the offender accountable can go a long way toward decreasing the traumatic effects of sexual violence. Examples include, "This is not your fault," and "I'm so sorry this happened to you."
SELF-DETERMINATION	So many choices have been taken away from this patient population. Take into consideration what the patient wants throughout the process of care. It is incredibly healing.

possible. It involves seeking to understand the connection between presenting symptoms and behaviors and the individual's trauma history. Also involved are professional relationships and interventions that take into account the individual's trauma history as part of efforts to promote healing and growth (Harris & Fallot, 2001). At the most basic level, trauma-informed care involves the provision of services and interventions that do not inflict further trauma on the individual or reactivate past traumatic experiences. Simply put, trauma-informed care helps the individual heal.

The trauma-informed principles for care provision have been developed for a variety of specialty areas. They are relevant for assessing and treating older adults who have experienced sexual violence, and include:

1. Recognize that recovery from trauma is a primary goal and that each person reacts to and copes with trauma differently
2. Collaborate with the patient for development of goals and interventions
3. Maximize patient control and choices in recovery
4. Recognize the patient's need for safety, respect and acceptance
5. Highlight the patient's strengths
6. Minimize re-traumatization during care delivery (Page 13)
7. Provide culturally informed interventions (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005)
8. Provide sexual assault advocacy services (Campbell, 2006; International Association of Forensic Nurses [IAFN], 2008)



Section Five

Provider responsibilities

The Joint Commission on Accreditation of Healthcare Organizations recognizes that care should be delivered according to the patients' needs and with the highest possible quality. In its requirement, *Additional Standards for Victims of Abuse*, the commission is explicit regarding the providers' role in identifying abuse and the facilities' role in educating staff on how to appropriately identify and handle suspected abuse. Specific standards exist for hospitals, long-term care and home care facilities, among other facilities (The Joint Commission, 2009).

The Provision of Care, Treatment and Services (PC) Standard 01.02.09 requires that the organization assess the patient or resident who might be a victim of possible abuse and neglect. For long-term care and home care, this includes assessing for exploitation (The Joint Commission, 2012b). By assessing patients who could be possible victims of abuse, health care organizations fulfill an important role in helping to protect patients (Bonnie & Wallace, 2003).

Each organization is expected to have:

- Known criteria to assist staff (at initial contact and on an ongoing basis) in identifying those who might be victims
- A list of private and public community agencies to which victims may be referred
- Education for staff on how to recognize signs of abuse, staff's role in follow-up when abuse is suspected, and legal/ regulatory internal and external reporting processes (The Joint Commission, 2012a)

The Rights and Responsibilities of the Individual (RI) Standard 01.06.03 articulates the patient or resident's right to be free from neglect, exploitation, verbal, physical, mental, and sexual violence (The Joint Commission, 2012c). Under this standard, each facility is expected to:

- Determine and identify how it will protect the patient or resident from abuse that might

occur while they are receiving care

• Evaluate each suspected case, allegation or observation of abuse that occurs within the facility

• Report all suspected cases, allegations and observations to appropriate authorities

In addition to understanding the Joint Commission regulations, providers must understand their institution-specific policies and state, tribal, or territory laws regarding how suspected sexual violence against older adults is handled. More information on mandatory reporting can be found in *Section Eight: Patient safety and reporting*.

In many hospitals, the sexual assault nurse examiner (SANE) has taken on the role of meeting the forensic needs of the patient who may have been victimized. A SANE is a registered nurse who has been trained in the comprehensive care of sexually assaulted patients of varying ages, which includes appropriate evidence collection. If your facility employs SANEs, it is appropriate to utilize them for older patients who might have experienced sexual assault. However, most health systems do not have 24-hour availability of trained SANE personnel.

In the absence of a SANE program, the provider still has an obligation to provide the standard of care when sexual violence is suspected. For the standard of care to be met, all staff must be educated in how to identify possible older adult sexual violence victimization and the response required for effective intervention. The list at right outlines specific situations in which older adult sexual violence should be part of the differential diagnosis.

When acute or recent sexual violence is suspected, a targeted approach to evaluation and treatment should be employed.

BE AWARE OF THESE SITUATIONS

• Disclosure of acute or recent sexual abuse

• Presence of intimate partner violence

• Signs/symptoms of anogenital infection

• Signs/symptoms of sexually transmitted infection

• Bite marks

• Unexplained bleeding and/or injury in the anogenital area

• Extreme, sudden change in behavior

• HIV

• Mouth sores or signs of oral infection

• Unexplained/inadequately explained oral and/or perioral injury

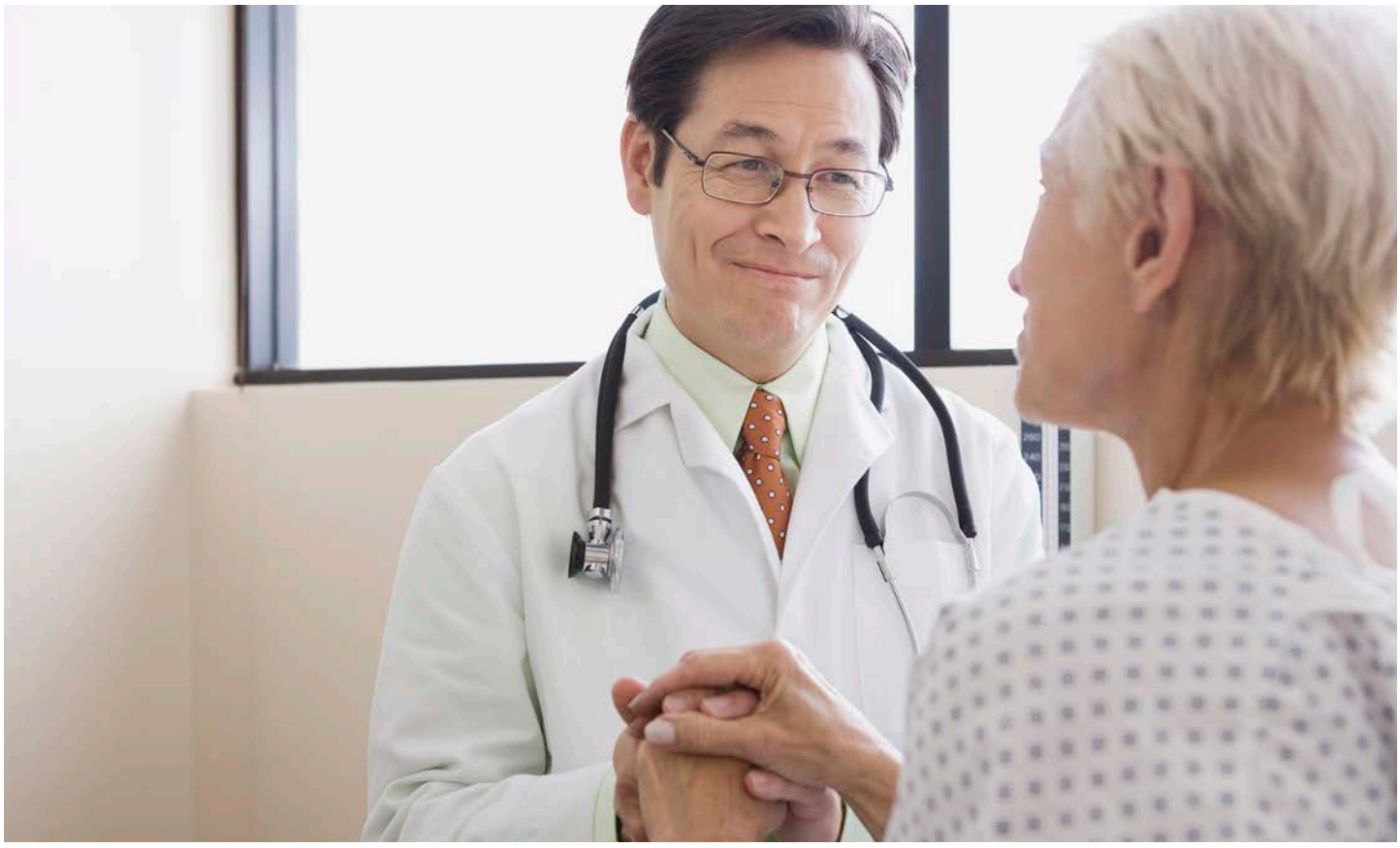
• Strangulation

Section Six

Gathering the Patient History

Each health care assessment involves gathering a history. Typically, the most accurate historian is the patient. While some older adults experience cognitive confusion due to medical conditions or trauma, providers should avoid assuming that older adults cannot provide accurate information or informed consent. If evidence suggests a cognitive problem, it is still important to converse with the older adult and determine what information he or she can provide regarding medical history and presenting problems. Family members, care providers, and even law enforcement might give information to providers that influence their independent assessment of the patient. The provider should take care to avoid allowing this type of bias to interfere in an objective assessment. Realize that substandard care, including actions that lead to malnutrition or dehydration, can cause older adults to appear less capable than they are. Some abusers deliberately interfere with the cognitive abilities of their victims (for example, by over- or mis-medicating) to make them more vulnerable (Ramsey-Klawsnik, 2006). A complete medical record review may also lend critical information to the provider's overall assessment and treatment plan.

Respect the patient's privacy, confidentiality, and safety by gathering his or her history separate from other individuals.



It is unrealistic and potentially dangerous to expect that a patient will disclose sexual violence in the presence of others, particularly their perpetrator. Providers will want to explain the need to ask questions related to sexual activity prior to asking specific questions. For example, a provider could begin the discussion by saying, "Because many people are forced into sexual activities they may not wish to be a part of, and because these things can affect your health, I am going to ask you some questions about this" or similar introductory phrases.

This approach can help the patient feel more comfortable with subsequent questions that might otherwise feel embarrassing or intrusive. If history-gathering from parties other than the patient becomes necessary, do so privately with consciousness of the possibility that the person giving the history could be the offender. Useful communication techniques are outlined in the table on Page 19.

If the older adult is experiencing cognitive difficulties, gathering history from family members or caregivers can be valuable. If the older adult lives at home and relies on a caregiver, the caregiver might inform providers of recent issues with the patient, as well as challenges the caregiver may be facing.

Dialogue about the care plan, whether or not more help is needed, and any frustrations the caregiver might be experiencing can assist in determining overall stress levels and coping mechanisms in the home. However, providers must use caution to protect patient

Communication techniques

(National Institute on Aging, 2008)

Address the patient directly whenever possible
Remain in the patient's line of sight using good eye contact
Consider medications that patient takes to determine the best time for an alert interview
Speak clearly (not loudly)
Ask one question at a time
Reassure the patient

confidentiality and safety. For example, history-gathering from a person who might be a perpetrator of violence against the older adult can seriously endanger the patient. Maintaining patient privacy while gathering information should be a top priority. If the older adult is in a care facility or has been transferred from one, the history should be gathered in the same manner: individual patient history followed by history from others who might inform the decisions regarding care provided to the patient. Implausible explanations, delays in seeking care, and unexplained injuries are always concerning.

Screening tools specific to adults in later life have been developed to assist medical providers in identifying mistreated or abused older adults. However, existing screening tools inadequately address the specific issue of sexual violence. The Vulnerability to Abuse Screening Scale (VASS) questions only allude to the issue of sexual violence by asking questions such as, "Has anyone forced you to do things you didn't want to do?" (Schofield & Mishra, 2003). A similar tool, the Elder Abuse Suspicion Index (EASI), goes slightly further by asking, "Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?" (Yaffe, Wolfson, Lithwick, & Weiss, 2008). With the multitude of assessment tools available that adequately address other forms of older adult abuse, providers should be aware of the need to adapt these instruments in a manner that ask direct questions concerning sexual violence.

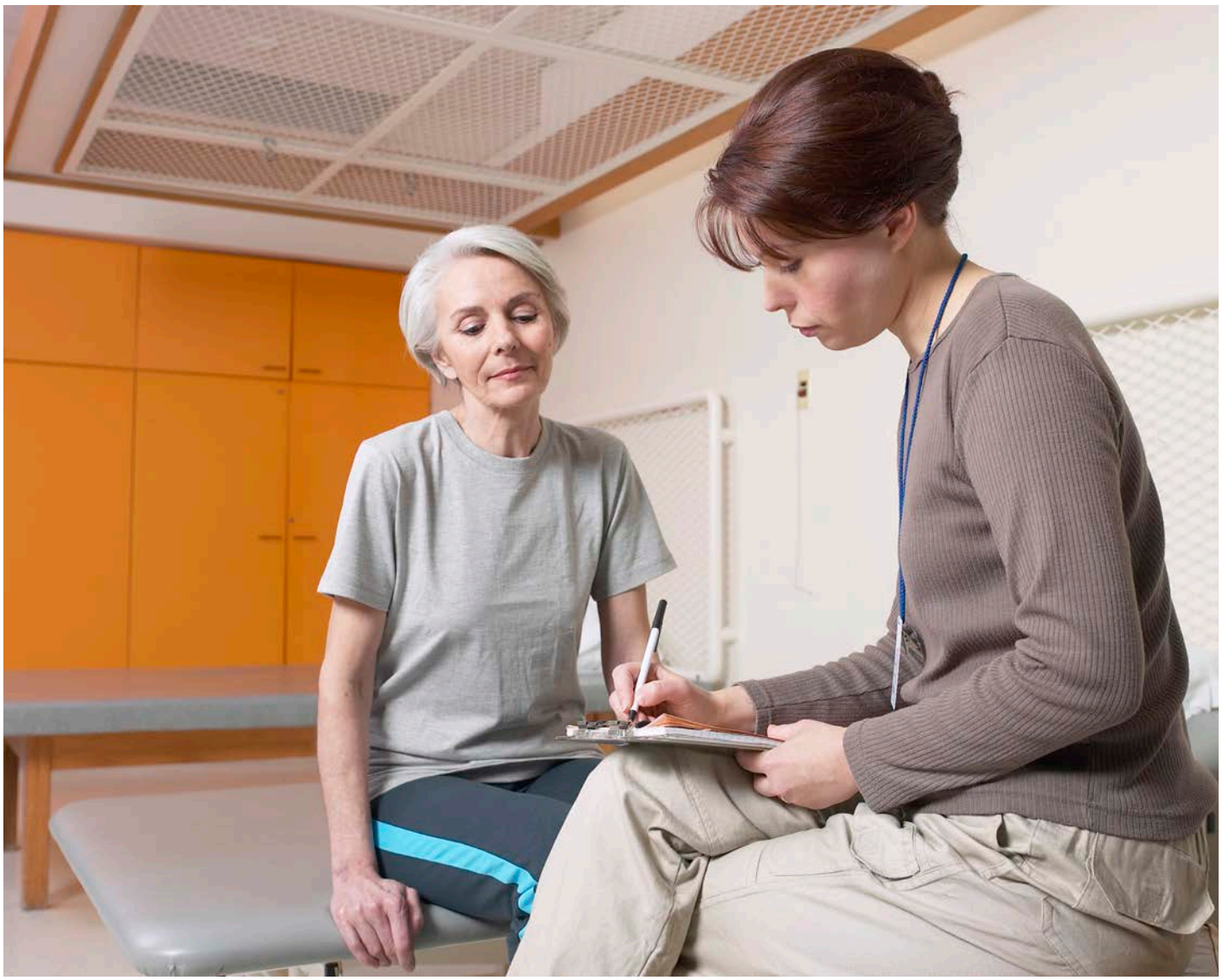
Examples of direct questions include:

Does anyone force you to do sexual things when you do not want to?

Does anyone do sexual things in front of you that you do not want?

Does anyone take pictures of your private parts?

Does anyone take pictures of you without your clothes on?

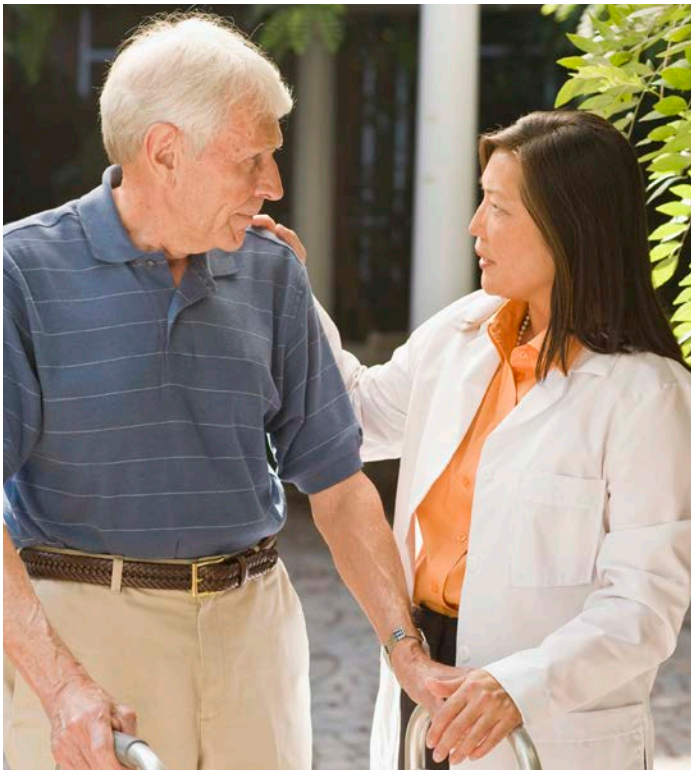


Examination & Evidence collection

Regardless of setting, the physical examination should include a complete head-to-toe assessment with review of systems.

A detailed anogenital assessment is always necessary when sexual violence is suspected against an older adult. A study of 125 females involved in older-adult sexual abuse cases reported more than half of the victims had at least one body part injured, almost half with signs of vaginal injury, and 35% with positive evidence for the presence of sperm (Burgess, Ramsey-Klawsnik, & Gregorian, 2008). How this assessment is carried out depends on the patient's physical ability with regard to positioning, and the patient's willingness to be examined. In female patients, a speculum exam might be necessary, depending upon the external anogenital examination findings and the ability of the patient's vagina to accommodate a speculum. Providers should thoroughly assess the external genitalia for injury prior to introducing a speculum. Genital injury is common in older adults after sexual violence has occurred, and further injury could be caused by speculum insertion (Poulos & Sheridan, 2008).

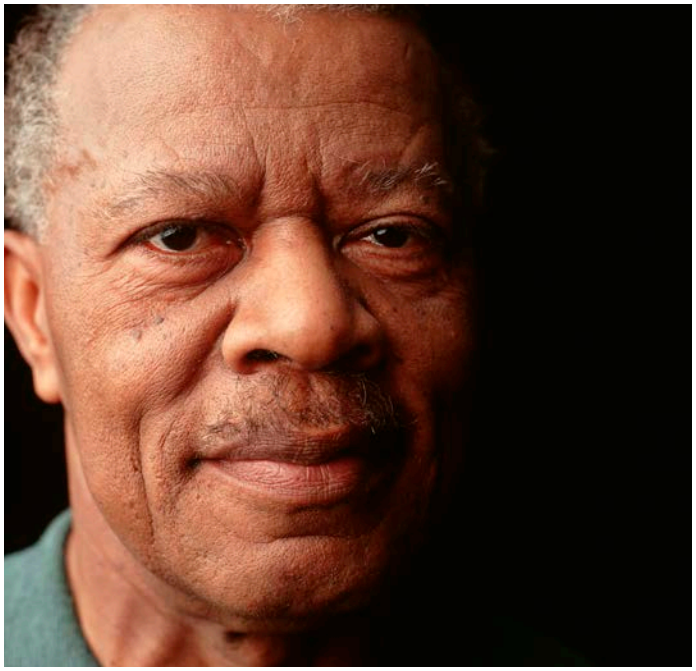
If the injury is significant enough to hamper a complete assessment, sedation might be necessary. The provider must obtain informed consent from the patient, remembering that he or she has the right to refuse any aspect of the exam, even with cognitive limitations. If the sexual violence is believed to have occurred



acutely (in the five days prior to examination), evidence collection should be offered to the patient.

Evidence collection

When evidence collection is necessary, local protocols and evidence-collection kits should be used if they're available. Typically, if a provider is unfamiliar with local protocol, emergency department staff, the sexual assault coalition, and/or the state health department might assist (NSVRC, n.d.). If no specific kit or protocol exists, follow the direction of the National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents (Littel, 2004). It is important that providers



be educated in available options for evidence collection, as most jurisdictions have some form of "anonymous" (otherwise unreported) evidence collection available when the patient is choosing not to report or does not wish to cooperate with law enforcement. The right to self-determination with regard to evidence collection and reporting is not automatically withdrawn due to a patient's age. When evidence is collected, it should be turned over to the appropriate law enforcement agency per local procedures.

In all instances in which evidence collection is determined to be necessary and consent has been obtained, the collection should co-occur with the rest of the patient's care.

Evidence collection basics

Informed consent

Ask the patient, "Is it OK if I collect some swabs from your mouth that might help us identify who did this to you?"

Buccal and oral swabs

Collect during the head, ears, eyes, nose, and throat portion of the Review of Systems.

External genital, penile, vaginal, cervical, and anal swabs

Collect during the genitourinary exam in males.
Collect during the pelvic exam in females.

Serum sample

Collect when all other lab work is obtained.

Section Eight

Patient safety and reporting

Patient safety is the priority of all health facilities and the ongoing responsibility of providers. Patient safety includes issues that led to the patient's admission, occur throughout their stay, and impact the patient at discharge. When there is concern that sexual violence might be occurring against an older adult, the provider is responsible for ascertaining as much information as possible about the violence to address health implications and safety issues. This information should always include who the possible offender is and what — if any — ongoing access the offender has to the patient. Discharging a patient to a live-in relative believed to be sexually violating the patient would be clinically inappropriate.

Because many cases are unclear on what has happened and who the perpetrator is, health care providers often are mandatory reporters. With the exceptions of Colorado, New Jersey, New York, North Dakota, and South Dakota, U.S. states and territories have laws that mandate reporting of suspected older adult abuse (Remick, 2008). Even if a state or territory does not mandate reporting, institutional policy might still support or require it, so health professionals will need to be familiar with their policy. Each jurisdiction varies slightly regarding where the report should be filed. Some require a report to Adult Protective Services (APS), others to local law enforcement, some to regulatory bodies, and some to all of these organizations. When the safety of the older adult is compromised, reports to multiple entities might be appropriate.

APS investigates allegations of abuse, neglect and exploitation of older or vulnerable adults. It is important to note that not all entities are called "Adult Protective Services," and the services that are offered can vary dramatically from jurisdiction to jurisdiction. APS at the state or local level are provided to improve the

safety of older adults who have experienced abuse; the agency receives and investigates reports of suspected abuse.

APS might provide or arrange provision of the following in substantiated cases (Brandl et al., 2007):

- Assessment of risk
- Assessment of capacity
- Case planning, intervention and supervision
- Civil court orders of protection
- Evaluation of service implementation
- Emergency, medical and social services
- Housing and economic services
- Legal services, including law enforcement intervention
- Support services.

It is important that providers do not confuse the role of APS with that of law enforcement. While APS investigates older and vulnerable adult abuse reports, it does not conduct criminal investigations regarding the abuse. This is the responsibility of law enforcement.

States vary in relation to availability of APS emergency services. Some, but not all, can respond to reports around the clock. Know the availability in your area.

Section Nine

Documentation

Documentation of the patient history should include information gathered from the patient as well as other parties, and should include quotations from the patient whenever possible. The complete assessment and review of systems should be documented, as well as the medical record review and any cognitive assessments. States, territories, and tribes might have specific sexual assault documentation paperwork for this purpose. Providers can contact their local emergency department, sexual assault coalition, or department of health to learn more about the availability of documentation.

All injuries should be recorded using appropriate body maps/diagrams indicating the type of injury, location, size, and color. No inferences should be made with regard to age of injury. When possible, and with the patient's consent, photographs of the injuries should be obtained and maintained as a part of the medical record. When photography is used as an adjunct to documenting injuries, the health care institution must have established guidelines, policies and procedures in place, and personnel must work within the established institutional regulations. The box below outlines minimum expectations with regard to these guidelines.

Digital cameras have become the standard used in most health care institutions because of their improved image quality at relatively low cost. Instant cameras and cameras with film requiring outside development of images are considered obsolete.

The following outlines appropriate photographic documentation:

1. **Patient identifier**
   (Name, date of birth, medical record number photographed to begin the series)

2. **Orientation image**
   (Full-length photo of patient appropriately draped/clothed)

3. **Injury/finding specific image**
   (Image depicting one injury/finding where the body location can be identified)

4. **Injury/finding specific close-up image without a standard**
   (Image depicting the same injury/finding close-up)

5. **Injury/finding specific close-up image with a standard**
   (Repeat the same close-up with a standard in the image depicting size and color)

Section Ten

Treatment considerations

Standards of care for sexual violence victims are well documented (World Health Organization, 2003), and typically involve addressing the short- and long-term psychological implications of sexual violence, treatment of physical injuries, handling pregnancy and sexually transmitted disease prevention and treatment as needed, and evidence collection when treated acutely.

When considering treatment for older victims, it is important to remember that while pregnancy prevention most often will not be necessary, there are patients for whom this must still be considered. Pregnancy has been well documented in women older than 40 (Spellacy, Miller, & Winegar, 1986). Menopause is defined as occurring when a woman's menstrual period has ceased to occur for a period of 12 consecutive months, typically between 40 and 58 years of age. If pregnancy is still a possible outcome and the patient is seen within the first five days of the assault, reproductive health services and options, including emergency contraception, should be discussed with the patient and emergency contraception should be offered if the patient is interested. If a pregnancy does occur as a result of sexual violence, if it ends in miscarriage or termination, health care providers will want to be prepared to submit tissue samples as evidence if the patient consents to evidence collection.

If there is any indication that the patient is at risk of acquiring a sexually transmitted disease,

the provider should discuss the risks versus benefits of prophylaxing the patient for N. Gonorrhea, C. Trachomatis, and Trichomoniasis; prophylaxis should be offered. Should the patient present a risk of acquiring HIV from the assault, and the patient is seen within 72 hours, non-occupational post-exposure HIV prophylaxis should be considered. Because of the significant side effects, providers should involve infectious disease expertise to assist in determining risk versus benefit of treatment.

While genital injury is more common in the older adult population, a minority will require surgical repair. When surgical repair is necessary, evidence collection should occur in the surgical suite or operating room prior to the repair, but after anesthesia to ensure pain control.

Section Eleven
Collaboration

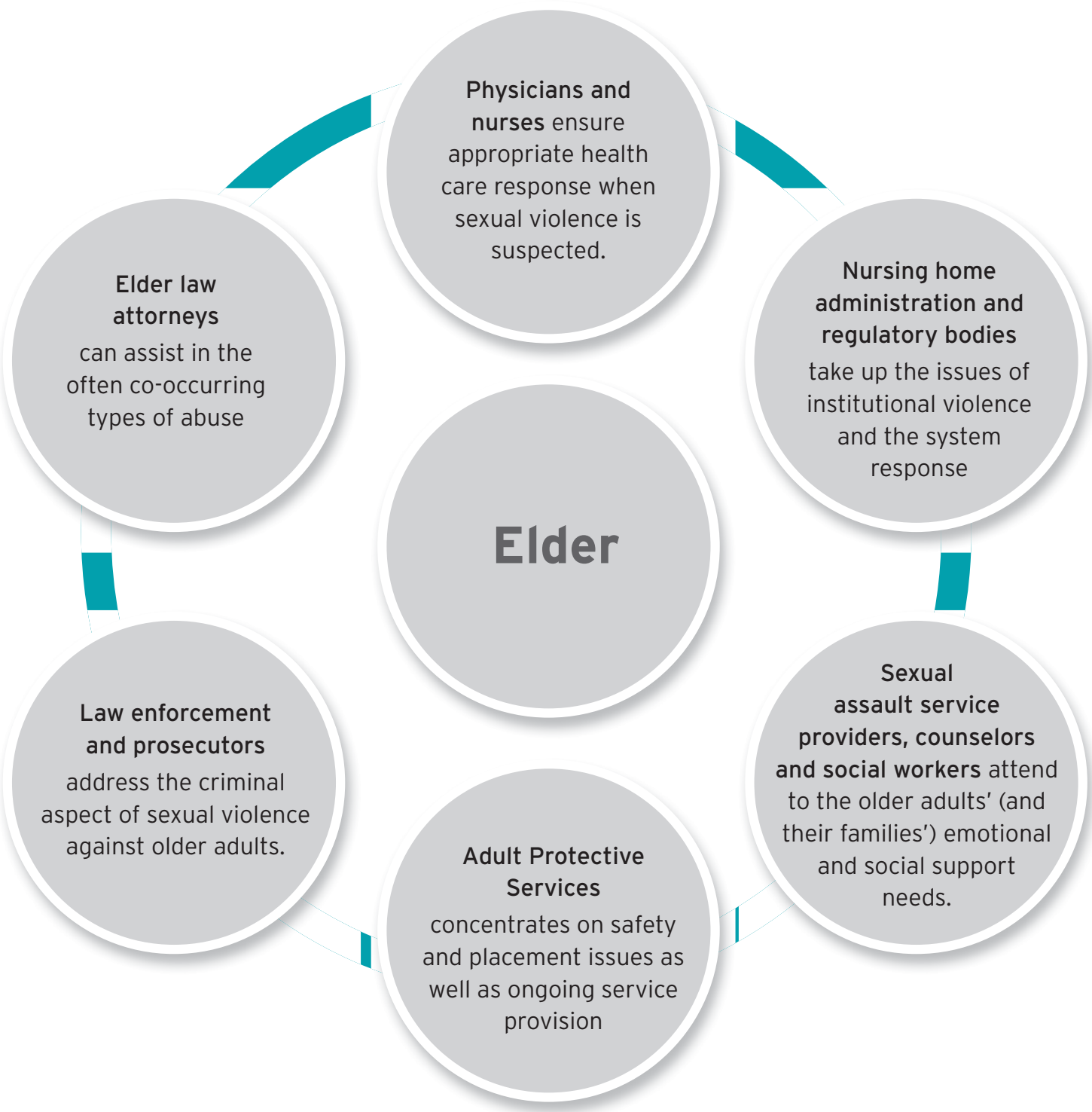
Collaboration within and outside the health care system is essential to an effective response to sexual violence against older adults. Communities without existing formal collaborations are encouraged to pursue this approach in a manner that works for the individual community. There are informal as well as formal collaborations in communities that address the issue of violence against adults in later life. Informal collaboration can be as simple as making the individual connection with appropriate agencies in an effort to establish lines of communication. This can often work more effectively than formal team approaches, particularly in communities where time and resource commitment are issues.

Formal teams might refer to themselves as elder abuse review teams, coordinated community response teams, or elder abuse task forces. Regardless of title, formal teams typically address the community response to sexual violence in older adults, the prevention of sexual violence in older adults, or both. The illustration on Page 29 identifies who might be a part of the multidisciplinary approach, with the older adult patient at the center of the collaborative response. The connection between team members is essential to decrease the likelihood of an ineffective response that leaves the older adult in continued jeopardy. More representatives than those mentioned here could be included on teams, depending on the community's needs.

Because sexual violence occurs in the home as well as in care settings (nursing homes, etc.), having representation from sectors that adequately represent both is important.

The National Aging Network is the largest provider network of home- and community-based care for older adults. It is a network that informal and formal teams will want to consider as an invaluable resource. The Aging Network provides home-delivered meals, personal care services, transportation, adult day care, respite care, information and support, and grant authorization for research, demonstration, and training projects.

Training of the disciplines involved should occur in a multidisciplinary team setting.



Because many of these individuals do not routinely interact, establishing a known and trusting relationship can decrease the chance of delayed response when sexual violence against older adults is suspected. While educational needs might differ between roles, there is enormous value in role definition, clarification, and understanding. Additionally, as specific responses and protocols are developed, the teamwork contributes to clarity among and between the roles.

Section Twelve

Conclusion

Sexual violence is a complex health and social crisis that requires a diverse, multidisciplinary, and collaborative short- and long-term response. It is imperative that our response includes and effectively addresses the victim. Until then, we will not have a true picture of how many older adults are experiencing sexual violence.

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Section Thirteen

References

Acierno, R., Hernandez-Tejada, M., Muzzy, W., & Steve, K. (2009). *National Elder Mistreatment Study: Final report* (NCJ 26456). Retrieved from the National Criminal Justice Reference Service: https://www.ncjrs.gov/pdffiles1/nij/grants/226456.pdf

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health, 100,* 292-297. http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2009.163089

Allan, M. A. (2002). Elder abuse: A challenge for home care nurses. *Home Healthcare Nursing, 20,* 323-330. http://journals.lww.com/homehealthcarenurseonline/pages/articleviewer.aspx?year=1998&issue=02000&article=00007&type=abstract

Anscombe, A. K., & Knight, B. H. (1996). Case report. Delayed death after pressure on the neck: Possible causal mechanisms and implications for mode of death in manual strangulation discussed. *Forensic Science International, 3,* 193-197. http://www.sciencedirect.com/science/article/pii/0379073895018867

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., ... Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report.* Retrieved from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

Bonnie, R. J., & Wallace, R. B. (Eds.). (2003). *Elder mistreatment: Abuse, neglect and exploitation in an aging America.* Retrieved from National Academies Press: http://www.nap.edu/openbook.php?isbn=0309084342

Boyd, C. (2011) *The impacts of sexual assault on women.* From the Australian Institute of Family Studies, Australian Centre for the Study of Sexual Assault: http://www.aifs.gov.au/acssa/pubs/sheets/rs2/rs2.pdf

Brandl, B. D., Dyer, C. B., Heisler, C. J., Otto, J. M., Stiegel, L. A., & Thomas, R. W. (Eds.). (2007). *Elder abuse detection and intervention.* New York, NY: Springer.

Briere, J. K., Kaltman, S., & Green, B. L. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress, 21,* 223-226. http://onlinelibrary.wiley.com/doi/10.1002/jts.20317/abstract;jsessionid=2D72A1C5C4FC886ED5CEE041C76F809E.f03t03

Section Thirteen

References Continued

Burgess, A. W., Ramsey-Klawsnik, H., & Gregorian, S. B. (2008). C*omparing routes of reporting in elder sexual abuse cases. Journal of Elder Abuse and Neglect, 20,* 336-352. http://www.tandfonline.com/doi/abs/10.1080/08946560802359250

Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems. *Violence Against Women, 12,* 30-45. http://vaw.sagepub.com/content/12/1/30

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. Trauma, *Violence, & Abuse, 10,* 225-246. doi:10.1177/1524838009334456

Connolly, T. (2011, March 2). *Testimony before the Senate Special Committee on Aging hearing on Justice for all: Ending elder abuse, neglect and financial exploitation.* Retrieved from http://www.aging.senate.gov/events/hr230mc.pdf

Dong, X., Simon, M., Mendes de Leon, C., Fulmer, T., Beck, T., Heibert, L., ... Evans, D. (2009). Elder self-neglect and abuse and mortality risk in a community-dwelling population. *Journal of American Medical Association, 302,* 517-526. http://jama.jamanetwork.com/article.aspx?articleid=184342

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. R. (2005). Trauma informed or trauma denied: Principles and implementation of trauma informed services for women. *Journal of Community Psychology, 33*, 461-477. http://onlinelibrary.wiley.com/doi/10.1002/jcop.20063/abstract

Harris, M., & Fallot, R. D. (Eds.). (2001). Using trauma theory to design service systems. In H. R. Lamb (Ed.), *New directions for mental health services* (No. 89). San Francisco, CA: Jossey-Bass.

Hawley, D. M., McClane, G. E., & Strack, G. B. (2001). A review of 300 attempted strangulation cases part III: Injuries in fatal cases. *Journal of Emergency Medicine, 21,* 317-322. http://www.sciencedirect.com/science/article/pii/S0736467901004012

International Association of Forensic Nurses. (2008). *Position statement: Collaboration with victim advocates.* Retrieved from http://iafn.org/associations/8556/files/IAFN%20Position%20Statement-Advocates%20Approved.pdf

The Joint Commission on Accreditation of Healthcare Organizations. (2009). *Additional standards for victims of abuse.* Retrieved from Futures Without Violence: http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_jcaho

The Joint Commission on Accreditation of Healthcare Organizations. (2012a). *Comprehensive Accreditation Manual for Hospitals: The official handbook.* Retrieved from http://www.jcrinc.com/Joint-Commission-Requirements/Hospitals/

The Joint Commission on Accreditation of Healthcare Organizations. (2012b). *Provision of care, treatment and services.* Retrieved from the University of Medicine and Dentistry of New Jersey: http://www.umdnj.edu/mdstfweb/The_Joint_Commission/Provision%20of%20Care%20Treatment%20%20Services.pdf

The Joint Commission on Accreditation of Healthcare Organizations. (2012c). *The rights and responsibilities of the individual.* Retrieved from the University of Medicine and Dentistry of New Jersey: http://www.umdnj.edu/mdstfweb/The_Joint_Commission/Rigst%20%20Responsibilities%20of%20the%20Individual.pdf

Lachs, M., & Berman, J. (2011). *Under the radar: New York State Elder Abuse Prevalence Study.* Retrieved from New York State Office of Children and Family Services: http://www.ocfs.state.ny.us/main/reports/Under%20the%20Radar%2005%2012%20 11%20final%20report.pdf

Section Thirteen

References Continued

Littel, K. (2004). *A national protocol for sexual assault medical forensic examinations: Adults/adolescents* (NCJ 206554). Retrieved from the National Criminal Justice Reference Service: https://www.ncjrs.gov/pdffiles1/nij/206554.pdf

National Center on Elder Abuse. (2012). T*he role of health care professionals in the prevention, detection, and intervention of elder mistreatment.* Orange, CA: Author.

National Committee for the Prevention of Elder Abuse. (n.d.). *What is Elder Abuse?* Retrieved February 15, 2013 from http://www.preventelderabuse.org/elderabuse/

National Sexual Violence Resource Center. (n.d.). *Organizations.* Retrieved December 4, 2012 from http://www.nsvrc.org/organizations?tid=8&tid_1=All

Payne, B. K., & Gainey, R. R. (2005). *Family violence and criminal justice: A life course approach* (2nd ed.). Cincinnati, OH: Anderson.

Poulos, C. A., & Sheridan, D. J. (2008). Genital injuries in postmenopausal women after sexual assault. *Journal of Elder Abuse & Neglect, 20*, 323-335. http://www.tandfonline.com/doi/abs/10.1080/08946560802359243

Ramsey-Klawsnik, H. (1991). Elder sexual abuse: Preliminary findings. *Journal of Elder Abuse & Neglect, 3*, 73-90. http://www.tandfonline.com/doi/abs/10.1300/J084v03n03_04

Ramsey-Klawsnik, H. (2003). Elder sexual abuse within the family. *Journal of Elder Abuse & Neglect, 15,* 43-58. http://www.tandfonline.com/doi/abs/10.1300/J084v15n01_04

Ramsey-Klawsnik, H. (2006). Complexities of mental capacity. *Victimization of the Elderly and Disabled, 9*(1), 1-2, 15-16.

Ramsey-Klawsnik, H. (2010). *Sexual violence in later life: A technical assistance guide for advocates.* Retrieved from the National Sexual Violence Resource Center: http://www.nsvrc.org/sites/default/files/publications_SVlaterlife_Guide.pdf

Ramsey-Klawsnik, H., Teaster, P. B., Mendiondo, M. S., Marcum, J. L., & Abner, E. L. (2008). Sexual predators who target elders: Findings from the First National Study of Sexual Abuse in Care Facilities. *Journal of Elder Abuse & Neglect, 20,* 353-376. http://www.tandfonline.com/doi/abs/10.1080/08946560802359375

Remick, L. (2008). *Penalties for failing to report elder abuse: Comparison chart with provisions from adult protective services laws, by state.* Retrieved from American Bar Association: http://www.americanbar.org/content/dam/aba/administrative/law_aging/2011/2011_aging_ea_failure.authcheckdam.pdf

Roberto, K. A., & Teaster, P. B. (2005). Sexual abuse of vulnerable young and old women. *Violence against Women, 11,* 473-504. http://vaw.sagepub.com/content/11/4/473

Schofield, M. J., & Mishra, G. D. (2003). Validity of self-report screening scale for elder abuse: Women's Health Australia Study. *The Gerontologist, 43,* 110-120. http://gerontologist.oxfordjournals.org/content/43/1/110

Shields, L. B. E., Corey, T. S., Weakley-Jones, B., & Stewart, D. (2010). Living victims of strangulation: A 10-year review of cases in a metropolitan community. *American Journal of Forensic & Medical Pathology, 31,* 320-325. http://journals.lww.com/amjforensicmedicine/pages/articleviewer.aspx?year=2010&issue=12000&article=00004&type=abstract

Spellacy, W. N., Miller, S. J., & Winegar, A. (1986). Pregnancy after 40 years of age. *Obstetrics & Gynecology, 68,* 452-454.

U.S. Census Bureau. (2008). *Projections of the population by selected age groups and sex for the United States: 2010 to 2050* (Table 2). Available at http://www.census.gov/population/projections/data/national/2008/summarytables.html

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2003). *Costs of intimate partner violence against women in the United States*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2010). *Elder: Definitions.* Retrieved from http://www.cdc.gov/ViolencePrevention/eldermaltreatment/definitions.html

U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Aging. (2008). *Talking with your older patient: A clinician's handbook* (NIH Publication No. 08-7105). Retrieved from http://www.nia.nih.gov/sites/default/files/TWYOP%209-11.pdf

Van der Kolk, B. A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics Of North America, 12,* 389-411. Retrieved from the Circumcision Reference Library: http://www.cirp.org/library/psych/vanderkolk/

World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence.* Retrieved from http://whqlibdoc.who.int/publications/2004/924154628X.pdf

Yaffe, M. W., Wolfson, C., Lithwick, M., & Weiss, D. (2008). Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI). *Journal of Elder Abuse and Neglect, 20,* 276-300. http://www.tandfonline.com/doi/abs/10.1080/08946560801973168

Section Fourteen

Care algorithm

Elder reports or is brought to a health facility with one of the following:

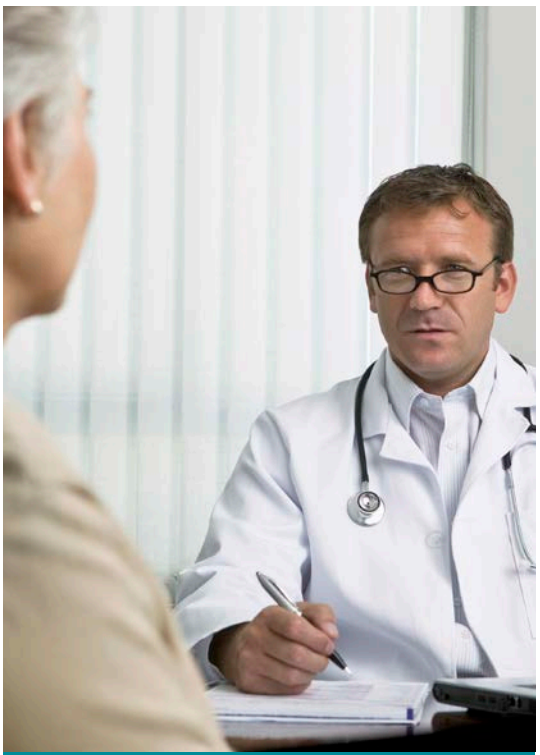
- A complaint/report of sexual abuse
- A caregiver who is concerned about sexual abuse
- The provider is concerned/suspicious about sexual abuse
- Genital bleeding or injury has been noted
- A sexually inappropriate circumstance was witnessed

The provider should always:

- Obtain history from the caregiver separate from the patient
- Obtain a history from the patient separate from the caregiver
- Obtain and review available patient medical history
- Determine if the patient lives at home or in a care facility
- If the patient lives at home, determine who else lives in the home and who cares for the patient
- Determine if the sexual contact was in the last 120 hours
- Determine if there was any delay in seeking care, and the rationale for the delay
- Determine if the patient is their own guardian

Less than 120 hours since last known contact

- Consent
- Physical assessment
- Injury/disease treatment
- Forensic evidence collection
- Documentation
- Consider the need and appropriateness of STI prophylaxis
- Evaluate the need and appropriateness of HIVnPEP
- Evaluate the need and appropriateness of emergency contraception*
- Evaluate the need to report per state, tribal, or local policy
- Safety planning



For all patients:

- **Community**
- **Social work when available**
- **Report to adult protection and law enforcement**
- **Safety planning**
- **Follow-up for medical care/ treatment as needed**

More than 120 hours since last known contact

- Consent
- Physical assessment
- Injury/disease treatment
- Documentation
- Consider testing for STI
- Consider HIV testing as appropriate
- Consider pregnancy testing*
- Evaluate the need to report per state, tribal, or local policy
- Safety planning

*There are vulnerable adults still with child-bearing years, where pregnancy and pregnancy prevention services must be considered

Section Fifteen

Resources

Administration on Aging (AoA)
www.aoa.gov
The mission of AoA is to develop a comprehensive, coordinated, and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities.

Center of Excellence on Elder Abuse and Neglect (formerly the National Center on Elder Abuse)
www.centeronelderabuse.org/resources.asp
The University of California, Irvine's Center of Excellence on Elder Abuse and Neglect, is committed to eliminating abuse of the elderly. Statewide and nationally, the center serves as a source of technical assistance, multidisciplinary training, useful research, and relevant policy.

National Adult Protective Services Association
www.napsa-now.org
The mission of NAPSA is to improve the quality and availability of protective services for adults with disabilities and older persons who are abused, neglected, or exploited and are unable to protect their own interests. NAPSA is the national voice of Adult Protective Service programs, professionals and clients, and advocates with national policymakers.

National Clearinghouse on Abuse in Later Life (NCALL)
www.ncall.us
Through advocacy and education, the National Clearinghouse on Abuse in Later Life (NCALL) works to improve victim safety, increase abuser accountability, expand coordinated community response, and ultimately, put an end to abuse in later life.

NCEA's State Directory of Helplines, Hotlines, and Elder Abuse Prevention Resources
www.ncea.aoa.gov/stop_abuse/get_help/state/index.aspx
State reporting numbers, government agencies, state laws, state-specific data and statistics, and other resources. Click on the state or territory to see a directory listing.

The National Consumer Voice for Quality Long-Term Care
www.theconsumervoice.org
Formerly NCCNHR, this organization advocates for public policies that support quality care and life; empowers and educates consumers and families; trains and supports individuals and groups to advocate for empowered consumers; and promotes the critical role of direct-care workers and the best practices in quality care delivery.

National Sexual Violence Resource Center (NSVRC)
www.nsvrc.org
NSVRC is a national information and resource hub relating to all aspects of sexual violence, and is funded through a cooperative agreement from the Centers For Disease Control and Prevention's Division of Violence Prevention. NSVRC collects and disseminates a wide range of resources on sexual violence. With these resources, NSVRC assists coalitions, advocates, and others interested in understanding sexual violence.

New York City Elder Abuse Center
http://nyceac.com
The New York City Elder Abuse Center was launched to improve the way professionals, organizations, and systems respond to elder abuse, neglect, and financial exploitation. It accomplishes this through an unprecedented level of collaboration and coordination in partnership with New York City's government and nonprofit agencies.

Nursing Home Compare
www.medicare.gov/NursingHomeCompare/search.aspx
Nursing Home Compare has detailed information about every Medicare- and Medicaid-certified nursing home in the country.

National Indigenous Elder Justice Initiative (NIEJI)
www.nieji.org
The National Indigenous Elder Justice Initiative (NIEJI) was created to address the lack of culturally appropriate information and community education materials on elder abuse, neglect, and exploitation in Indian Country.

Sexual Assault Forensic Examiner Technical Assistance Project (SAFEta)
http://safeta.org
The SAFEta project provides technical assistance around the *National Protocol for Sexual Assault Medical Forensic Examinations* (National SAFE Protocol of 2004), which provides details on the roles of responders to sexual assault as part of a coordinated community response. Additional technical assistance is provided with regard to the companion to the protocol, the *National Training Standards for Sexual Assault Medical Forensic Examiners* offering a framework for the specialized education of health care providers who wish to practice as sexual assault forensic examiners.

The National Long-Term Care Ombudsman Resource Center
www.ltcombudsman.org/about-ombudsmen#Ombudsman
Long-term care ombudsmen are advocates for residents of nursing homes, board and care homes, and assisted living facilities. Ombudsmen provide information about how to find a facility and what to do to get quality care.

US Department of Health and Human Services National Institute on Aging
www.nia.nih.gov
The Institute's mission is to support and conduct research on aging; foster the development of research on aging; provide research resources; disseminate information about aging and advances in research to the public, health care professionals, and the scientific community.