

**Elder Abuse Testimony to the NYS Assembly Standing Committee on  
Aging and NYS Assembly Standing Committee on Judiciary  
February 7, 2008**

My name is Risa Breckman and I am the Director of Social Work Programs and Education at Weill Cornell Medical College's Division of Geriatrics and Gerontology and an Assistant Professor of Gerontological Social Work in Medicine there. Thank you for this opportunity to testify on behalf of the Division of Geriatrics and on behalf of the Geriatric Mental Health Alliance of New York. I am going to focus my comments today on the mental health needs of elder abuse and neglect victims.

Mental illness among older adults is a significant problem. Over 20% of people 65 and older have a mental illness or substance abuse disorder. About 25% have clinically significant symptoms for depressive disorders with 5% suffering major depression. And anxiety is twice as common as major depression.

We know from research that elder abuse victims suffer from depression more commonly than their non-abused counterparts. Depression often leads to social isolation, which is itself a risk factor for abuse. What follows? Hopelessness. This, in turn, increases the risk of suicide.

But the emotional devastation of abuse encompasses far more than depression. My clinical experience and that of my colleagues informs that anxiety is common for victims, due to the trauma they experience, their on-going fear for their safety and the worries they have for their abusive family members about whom they often care deeply. Victims feel shame and guilt which also contribute to social isolation.

As hard as it is to believe, in NYC in the 21<sup>st</sup> century, older adults are not routinely screened for mental health problems—or elder abuse—in the many traditional and non-traditional settings where they receive services including, physicians offices, senior centers, social and medical adult day care programs, home health services and case management programs.

Why does this matter?

Elder abuse victims who are depressed or have other debilitating mental health problems can't really protect themselves. Imagine being elderly and isolated, having been physically injured and worn down from abuse or neglect. Now imagine trying to develop and follow a safety plan, obtain an order of protection or find somewhere else to live while experiencing the fatigue, worthlessness and indecisiveness associated with depression. This is asking an abuse victim to perform a Sisyphusian feat. Depression may be a consequence of abuse, but it also puts elder abuse victims at risk of continued abuse.

How can we help empower elder abuse victims to make choices leading to a life without mistreatment? We have four suggestions:

*First, we should require publicly funded health, mental health, and elder service providers to screen for, assess and intervene in elder abuse and neglect.* Mental health problems in older adults are frequently overlooked by providers. While we advocate for the improved screening and treating of geriatric mental health problems, we also promote the identification of and response to abuse. Sadly, a great many physicians and mental health professionals don't know how to identify and respond to elder abuse. The idea that an abused older adult could be screened for depression, treated with an antidepressant and then sent home *without the underlying abuse being acknowledged, much less dealt with,* is outrageous. We need guidelines for screening, assessment, and treatment of elder abuse and neglect as well as training and supervision for existing personnel.

*Second: We should increase the capacity of existing geriatric mental health providers and fund programs in underserved areas.* Currently in NYS only ¼ of older adults with mental disorders receive treatment from mental health professionals. Another ¼ get treatment from primary care physicians, most of whom are not prepared to provide adequate treatment. Half get no treatment. Mental health programs in NYC serving older adults are operating at capacity and have waiting lists. Some neighborhoods with concentrations of older adults are grossly underserved.

Independent Medicare providers—social workers, psychologists and psychiatrists—are in short supply and hard to find. At Cornell, a few years ago we launched an online directory of independent NYC Medicare mental health providers. The 1,050 providers in the directory collectively speak over 37 languages, 15% have expertise in elder abuse and many do home visits. This is not enough providers, but it certainly is helpful to people to know who may be available. Unfortunately, the database is getting old, but The Centers for Medicare and Medicaid are not cooperating in our effort to update our information. Perhaps you could bring some pressure to bear politically to get them to help.

*Third, we need to fund innovative services to reduce the social isolation of elder abuse victims and identify those hidden from view.* In Ireland, since 1998, there has been a “Senior Help Line,” a national confidential listening service for older people available seven days a week for the price of a local call. It is staffed by 350 trained older volunteers. They received 5,000 calls last year and successfully identified 1,000 elder abuse and neglect victims. New Yorkers deserve a helpline like this.

*And four, we should fund case coordination and review groups.* These groups address significant clinical and systems issues that elder abuse victims encounter in the legal, health care, social service, criminal justice, housing and mental health realms. Dr. Mark Lachs and I Co-Chair one such group: The Manhattan Elder Abuse Case Coordination and Review Team; a multidisciplinary group with over 40 representatives from criminal justice, health care, housing, APS, social services, and psychiatry. There is no special funding to run this group in NYC. The Orange County Forensics Center in California, a similar but further evolved group, conducts case reviews; in-home medical and mental status, and evidentiary investigation; taped victim interviews; education;

consultation; and research. They can do all of this because they are well funded. We can do as well in NYS – but we need funding.

In closing, we are confident that with help from the State of New York, we can successfully help elder abuse victims achieve a better quality of life in their final years.

Thank you.

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