Failing Francis: A Public Health Response to Unfit Housing

MARPHLI Case Study in Policy Development/Assurance

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A. Title: Failing Francis: A Public Health Response to Unfit Housing.

B. Functional Area: Policy Development/Assurance

C. Case Setting:

In 2005 an Environmental Health Specialist with a local health department responded to a normal housing complaint. Like so many other times, the case turned into anything but normal. The inspector found an elderly man in grave danger. Not only was the house unfit for human habitation, the man was being neglected by his caregiver. The inspector set out to get Francis help. What the inspector thought should be simple call, turned into a failed attempt to save a man's life. As the case spun in red tape, and fell through the cracks, the elderly man died before the courts would take any action. This case study looks at what laws are already in place, how they were used and will also look at policy development to prevent similar cases from ever being repeated.

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The F.L.I.E.S. (Finding Leadership Initiatives for Environmental Safety)
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Introduction:

How a person lives is of major importance to his/her overall health and well being. How one lives also impacts society either positively or negatively. The conditions inside a home can promote or generate diseases. A public health response is warranted when the factors contributing to disease can impact on the individual and community in an adverse manner.

Habitability of ones home' relates to the health and living standards inside ones home. The definition of habitability is "housing that provides the inhabitants with adequate space and protecting them from cold, damp, heat, rain, wind or other threats to health, structural hazards, and disease vectors" (High Commissioner of Human Rights, 2001).

Poor habitability of housing secondary to filth increases the risk of associated diseases, which can adversely impact society on a both small and large scale. On a small scale, one neighbor is affected by another neighbor's lack of sanitation and could experience rodent infestation. On a larger scale, filth and its associated diseases caused the loss of millions of human lives during the plague. "Poor housing is always associated with high rates of morbidity and mortality, yet housing is generally not high on the list of societal needs and governmental priorities" (Thiele, 2002).

A public health response has many players. Some are regulators, some are health care providers and others are support staff. Other players that are often overlooked in the response are the political forces in the community, the state and even the nation. One of the challenges facing local health departments is the economic situation. Anticipated decreases in public health funding and subsequent job losses will have a negative impact in communities as the demand for services increase. Living conditions for many people will decline particularly when those conditions were marginal prior to job losses and life changing situations. A key challenge for local health departments and communities will be the ability to respond to this potential crisis.

The Tragedy of Francis:

The following timeline has been drawn from Local Health Department records. Our primary character, 84-year old Francis X ultimately dies of gross malnutrition and a gangrene infection. Francis' adult grandson subsequently pleads guilty to a felony charge of "neglect of a dependent" for his involvement in his grandfather's death. Sixty days prior to Francis' death, the Local County Health Department (LHD) discovers that Francis and his adult grandson are living in deplorable, unsanitary conditions. In response, the department initiates action to remove Francis from the home while simultaneously reporting the situation to the local Adult Protective Agency. Other key players become involved in the situation during the course of the sixty-days, including an emergency room doctor, a police officer, and the courts. Conditions within the home are never significantly improved during this period. Despite all of this, Francis is able to continue living in the home until being hospitalized just days before his death.

- **Monday, July 11th; Initial health department inspection & response:** A LHD inspector initially visited Francis' residence in response to a complaint of an unfit, unsanitary housing situation. The inspector asked to inspect the home under a general authority granted under state law to investigate "possible cause of disease." Permission was granted. Significant amounts of animal waste and an overwhelming odor were observed in the home. Initially, the inspector had hoped to achieve a voluntary cleanup of the home. However when Francis' grandson returned home, he made it clear that the home would not be cleaned unless the residents were forced to do so. He also verbally threatened the inspector, necessitating police involvement.

  Without the ability to achieve voluntary compliance, the LHD inspector had to make decisions about whether a cleanup could and should be forced in this case. The inspector knew that powers granted in an existing state code (IC 16-41-20) could be used by a local Health Officers or their designee to declare a home "unfit for human habitation" if warranted in the opinion of the Health Officer/designee because of "the existence on the premises of an unsanitary condition that is likely to cause sickness among occupants of the dwelling." By the powers granted in this law, the Health Officer/designee could then order the property owner to either correct the situation or have all occupants vacate within a specified period of time.

  The LHD inspector also realized that IC 16-41-20 grants a discretionary power in which a health official can order such actions. The inspector had developed strong convictions during her career in public health that severely unsanitary homes do promote the spread of disease and do pose a threat to public health. Thus, the decision was made that action should be ordered.

The inspector notified both residents the home was being declared “unfit for human habitation” and they would have to vacate within one week unless sanitation within the home could be significantly improved. A written order was also served.

Upon returning to the office, the inspector contacted the Adult Protective Services agency (APS) and spoke with the local investigator regarding the conditions within the residence. The investigator explained that the home had been declared unfit for human habitation. The local APS investigator responded the that the agency would open an investigation as soon as possible.

- **Monday, July 18th; Second health department inspection:** Upon entering the home, it was apparent to the LHD inspector the conditions within the home remained unchanged. The residents refused to obey the health department’s order to vacate the home.

  The LHD inspector understood that a court order would be required to have Francis and his grandson removed from the home by police force. The health department attorney was contacted and a request was made for assistance in the matter. The attorney pursued a court order on behalf of the Health Officer to have Francis and his grandson removed in accordance with IC 16-41-20. A hearing was scheduled.

- **Thursday, August 4th; APS initial investigation:** The Adult Protective Services (APS) agency investigator made an initial visit to Francis’ home. He contacted the LHD inspector and reported that living conditions within the home were still very bad.

  However, the APS investigator explained that Francis had refused help and appeared to be competent to make his own decisions regarding his well being. Although living conditions within the home were clearly unsanitary, the APS investigator explained that protective actions could only be forced on Francis by APS via court action IF the investigator could convince a judge of *all* of the following (see IC 12-10-3-2 and 460 IAC 1-2-11e):

  1. Francis was not competent to make his own decisions regarding his own welfare.

  2. The conditions were clearly harming Francis or threatening to harm him.

  3. The least restrictive protective measures possible were being requested.

The APS investigator expressed concern about convincing a local judge that Francis was not competent to make his own decisions. Though his condition could be re-

evaluated in the future, the APS investigator would not pursue court-ordered protective measures at this time.

- **Friday, August 5th (AM); The hearing to remove Francis; LHD vs. residents:** The LHD attorney petitioned the court to issue an order that would ultimately enforce the Health Department's original order requiring Francis and his grandson to either bring the home into compliance or vacate it. Although Francis's grandson argued that it was his and his grandfather's right to live as they choose, the judge ruled in favor of the LHD and issued the requested order. However, the judge also granted a 30-day extension before the home had to either be brought into compliance or be vacated. Two weeks had already passed since the initial LHD deadline had expired.

- **Friday, August 5th (PM); Events following the hearing:** The judge ordered that the LHD inspector visit the home again and provide specific instructions to the residents regarding the required cleanup. The LHD inspector and an accompanying police officer returned to the home and found conditions to be unimproved.

  In addition to the conditions of the home, several other observations potentially related to Francis' health and welfare troubled the LHD inspector and the accompanying police officer. For example, little to no food was observed within the home. Francis' clothes were soiled. Francis repeatedly stated to his grandson in front of the LHD inspector that he had no oxygen for his machine. The LHD inspector conveyed these new observations to the APS investigator that had previously evaluated Francis' situation. The accompanying police officer later filed a report of "neglect of dependent" based upon his observations during this visit.

  After explaining that a "neglect of dependent" charge would be filed against Francis' grandson, the police officer convinced the grandson to take Francis to the hospital emergency room for a medical evaluation.

  The LHD inspector contacted the hospital emergency room physician on duty and explained the situation regarding Francis' home and the lack of food/oxygen. A request was made by the inspector to the Emergency room physician to hold Francis for a mental health evaluation up to 72 hours. The results of such an evaluation could have served as evidence had APS decided to pursue court ordered protective measures at a later time. The ER physician made a determination that a mandatory detention was not warranted after Francis' grandson explained to him that APS was currently involved in the situation.

Francis left the ER after two hours and returned to the condemned home with his grandson.

- **Friday, September 9th:** Thirty days had passed since the initial August 5th hearing and the judge had scheduled a hearing to re-evaluate the situation. However, Francis' grandson failed to appear in court.

  The APS investigator contacted the LHD inspector in the afternoon and stated that APS had re-evaluated the situation and would seek court-ordered protective actions. All documentation pertaining to the case was requested to assist in obtaining court intervention. The APS investigator also explained that Francis's health had deteriorated further and had been admitted to the local hospital.

- **Monday, September 12th:** Francis died in the hospital. His death certificate indicated gross malnutrition and a gangrene infection caused his death.

- **December 20th, the following year:** Francis' adult grandson pled guilty to one count of "neglect of a dependent resulting in bodily injury," a class C Felony. The judge also ordered the defendant to undergo a psychiatric evaluation and participate in any recommended treatment program after serving his sentence.

The Impact of Francis' Death on Local Agencies and Policies:

Within weeks of Francis' death, a series of round table meetings facilitated by the Local Health Department began to discuss how agencies could coordinate better, improve policies, and work together to prevent similar situations in the future. Representatives from Adult Protective Services, hospital social services, local Area on Aging, LHD, and law enforcement participated in the series of discussions. A case review and analysis was initiated within the LHD that included the Health Officer, Health Department Administrator, environmental health inspectors, and the Health Department Attorney. Critical changes were implemented as a result of the discussions.

Multi-agency meeting series: All agencies attending the first multi-agency round table quickly came to acknowledge the situation as a multi-system failure in which numerous agencies shared blame. More effective communication was needed. Assumptions had been made that other agencies were already effectively addressing the situation, and that those agencies had the capabilities to effectively do so. Some had failed to realize the immediate potential for serious harm to Francis. The final outcome made the failure of the overall group harshly evident.

One key benefit of the interagency discussion series was the development of better understandings of other agencies roles, responsibilities, and limitations. Agencies reviewed their own policies, governing laws, and mission statements and presented them during the meeting series. Key laws and policy statements governing agencies' responsibilities and limitations were compiled and presented to all participants. Representatives from each agency acknowledged that no one agency could effectively address such cases alone. Early in the discussions, agency representatives began to seek opportunities to assist other agencies in addressing future situations.

Agency representatives also developed more effective, positive working relationships with one another as a result of these discussions. In the future, suspected abuse/neglect and other issues could be conveyed directly to individual contacts as opposed to utilizing the general numbers and e-mail addresses available to the public. Representatives became comfortable contacting other agencies to ask questions and report questionable cases that may not have otherwise been reported.

Following much discussion and brainstorming, the group compiled a list of resources that could have benefited Francis prior to his death, and a list of resources that could potentially *be developed* to benefit someone like Francis in the future. The first list was intended as a tool to help involved agency representatives better serve individuals in future cases. The second was intended to summarize larger changes that agencies could work towards and/or advocate. These lists are included as appendices C and D.

The review of this case identified the need to better recognize and address the broader, underlying issue of elder abuse/neglect. Organization representatives involved in the ongoing case discussion developed a better understanding of the signs and symptoms of elder abuse. The group learned that every year an estimated 2.1 million Americans age 65 or older have been injured, exploited or mistreated by someone they depended on for care or protection. They learned that one in fourteen incidents of elder abuse in domestic setting, even excluding incidents of self-neglect, goes unreported (National Center on Elder Abuse, Washington DC 2005). As with this case, they also learned that the perpetrators of 90% of all reported elder abuse cases are family members. Other statistics the group complied during their research are included as Appendix F.

A subcommittee within the group began to develop a fact sheet to distribute to community organizations to further create an awareness of the issue. This is attached in Appendix E. Another subcommittee assumed responsibility for engaging the media to increase public awareness of the elder abuse and neglect.

Changes/improvements within LHD policies: The Health Officer, department administrator, attorney, and environmental health inspectors worked to develop an expedited process by which individuals could be forced to either clean or vacate extremely unsanitary housing. For serious cases of unfit housing, the health department attorney would present evidence from environmental inspectors and directly petition the court for an order of abatement or for removal of occupants from the premises. The petitions would include requests for specific measures, such as police action, to make the court orders realistically enforceable. The health department would no longer issue formal orders prior to seeking court-ordered action.

Arrangements were also made between the Health Officer, department attorney, and courts to develop an Environmental Court to hear cases every Friday morning. The Environmental Judge studied the rules that govern local Health Departments and the scope of their jurisdiction. This action ultimately benefited the department's enforcement efforts regarding other public health issues well beyond the housing program.

The LHD's environmental division engaged in discussions regarding what did vs. did not constitute a dwelling that would be "unfit for human habitation" and the situations that would warrant a court order to abate or vacate a home. The Local Health Officer clarified a working policy for the department regarding the severity a situation must reach before initiating court action under the department's new, more aggressive process.

It was also suggested that a public outreach campaign should be initiated on the issue of individuals living in unfit housing and being vulnerable to abuse and neglect. By educating the public, it was hoped, reporting of problems would increase and public support of the LHD's stance on unfit housing would evolve. The LHD inspector involved throughout Francis' case volunteered to spearhead this initiative. A series of presentations was prepared and delivered to area schools and applicable university classes/groups. Publicity from a local newspaper regarding the presentations also strengthened the department's efforts on a broader scale.

Key Agencies/Players:

Below brief descriptions are provided for key agencies which were involved with Francis' situation and which participated in the multi-agency, round-table discussions following his death.

Local Health Department: LHD's are organized for the purpose of health promotion and communicable disease prevention for the entire county. Risk reduction and public health awareness are directed towards entire communities and individuals, of all ages, to achieve optimal health. Departments facilitate various programs that educate, enforce, and provide services for the promotion and maintenance of a healthy environment. Under Indiana state law IC 16-41-20-1, local Health Officers are granted the *discretionary* power to declare homes meeting certain general criteria "unfit for human habitation" and to order that the homes be vacated within 5-15 days if problems have not been corrected.

Elected County Health Officer

Department Administrator/Supervisor

Environmental Health Specialist

Local Hospital: These promote wellness and improve the health status of the people of East Central Indiana and surrounding areas through patient care, health education and medical research.

Emergency Room Physician

Social Services Department

Adult Protective Services: The Adult Protective Services (APS) Program was established to investigate reports and provide intervention/protection to vulnerable adults who are victims of abuse, neglect, or exploitation. In Indiana, APS employs investigators who may refer individuals to services from other agencies and who may petition the courts to order protective measures for adults meeting certain criteria. The APS program in Indiana does not employ caseworkers to regularly check back on individual situations; such is a key difference between APS and Child Protective Services in the state. APS investigators operate out of the offices of county prosecutors throughout the state. If the APS Unit has reason to believe that an individual is an endangered adult, the adult protective services unit shall investigate the complaint or cause the complaint to be investigated by law enforcement or other agency and make a determination as to whether the individual reported is an "endangered adult." To be eligible for service under this program, an individual must be a resident of the state of Indiana, 18 years of age or older, physically or mentally incapacitated and reported as abused, neglected or exploited. To be eligible for court-ordered protective measures, an APS investigator must also convince the courts that the affected individual is incapable of managing or directing their own care, and that the individual is actually being harmed or threatened with harm. Indiana is the only state in which the APS program is a criminal justice function. Full time investigators operate out of 18 county prosecutor's offices statewide. In the state fiscal year 2004, APS investigated 15,080 reports. Case loads as high as 100-350 at any given time are common for APS investigators' according to investigator L. Kanable (personal interview, 12/8/08).

Investigator

Police/Sheriff's Department: The men and women of law enforcement are committed to preventing and combating crime by providing quality customer service. Officers are highly trained and adept in responding to emergency and other calls for service. They are committed to a mission of preserving the peace and protecting the public.

The goal of the police is to address community problems and assure a safe community through directed and routine patrol; to provide primary law enforcement services to the public 24 hours each and every day of the year. They are the first to respond to calls for service throughout the city. Officers of the Uniform Patrol Division also handle high liability incidents, including crimes in-progress, violent altercations and medical emergencies.

Uniform Police

Shift Supervisor

Closing Thoughts:

This case study illustrates a serious subject that should concern all communities throughout the United States. The voice of the victim often goes unheard. Many of the aging adults in our country are homebound. The home environment is unknown until it deteriorates into not only a hazard for those living in it, but also for those living in the same community.

Such an environment can seem somewhat normal to the occupant who feels hopeless in addressing how to improve it. The lack of knowledge by health professionals who may interact with affected individuals in emergency rooms or doctors' offices allows such problems to go unabated until regulators such as LHD's require intervention.

The Frances X case was successful in bringing key community people together to learn from the situation, begin addressing gaps, and identifying areas for improvement. It identified a need to restructure current policies and pull in other community resources. It was discovered that some potentially useful resources had been available, but had not been utilized.

The need to develop a funding program to address this issue and this population is clear. Current laws to protect one's rights in their homes can impede agencies and organizations whose job it is to ensure one's safety in the home and that one's needs are being met. The lines are unclear and it will be a hard road to define how best it can be addressed. Preventive measures are a good start. Defining ongoing research and findings are clearly needed to address how best this can be implemented in our communities.

This case could be about your grandparents, your aunts and uncles, or your neighbor who live down your street. Everyone is encouraged to take a pro-active start in his or her own community and educate others about substandard housing and the aging population. People who live in unfit housing are suffering. It is unclear most of the time whether it is by choice, by mental illness or by the fact they have no other resources. But what is clear, you cannot take the public out of public health. Webster's dictionary defines public as "the people as a whole." As humans, we must act to never Fail Francis again.

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Appendix A.

Indiana Laws Related to Health, Sanitation, and Safety:

IC 16-41-20-1
Dwellings unfit for human habitation

IC 16-20-1-25
Unlawful conditions; abatement order; enforcement

Appendix B.

Indiana Laws Relating to Elder Abuse / Adult Protective Services

IC 12-10-3
Chapter 3. Adult Protective Services

IC 12-26-5
Chapter 5. Emergency Detention

IC 12-26-4
Chapter 4. Immediate Detention

Appendix C.

Actual Resources Currently Available:

- A request could have been made to the local churches or volunteer groups to assist with a massive clean up of the house so that Francis could have remained in the home.

- A referral could have been made to the local health department nurse to come to the home, do a medical evaluation, and make recommendations based on findings.

- The primary medical physician and his office staff would have been a great resource to pull in and get involved in the issues of wound management, the oxygen tank being empty, evaluating if a self-care deficit exists, assuring that Francis was taking medications as prescribed, and oversight of other medical referrals.

- A local home healthcare agency, covered in full by this some individual's disability insurance, could have employed a nurse to do home visits and evaluate whether medications were being taken as prescribed, to follow-up with the durable medical equipment company, to assure that the oxygen tank remained filled and accessible. A home health aide could have also assisted with personal hygiene/bathing assistance.

- A local pharmacy or DailyMed Pharmacy may have had a program that drop ship's medications in pre-packaged, easy to manage packets. These are delivered straight to the home adhering exactly to physician's orders. Such a program promotes medication compliant which can impact the cognitive and functional status. A DailyMed Pharmacist would be assigned as oversight and would complete a medication review to ensure there would be no medications that could contraindicate each other (working with the primary care physician).

- A referral to the local Areas on Aging for a Waiver program could have provided private duty assistance for errands, grocery shopping, preparing meals, house upkeep and other misc. needs help promote someone with a self-care deficit to live independently. This is a free program funded with state dollars.

- A referral to Meals on Wheels could have delivered a hot lunch Monday-Fridays and a sack lunch for dinner to ensure nutritional status is met.

- To ensure the grandson was mentally fit to make decisions on behalf of his grandfather; a request for a judge to mandate a psychiatric evaluation on Francis' grandson could have brought light to whether or not his decision-making ability was impaired. He was the only resource Frances had.

- Also regarding Francis' grandson, a referral to Meridian ACT program could have provided a behavioral health specialist to do home visits, evaluate mental status, and administers psychiatric medications to ensure compliance.

- A referral to LifeStream (the local Area on Aging) could have provided free transportation to all the medical and health appointments needed to effectively manage Francis' medical needs.

Appendix D.

Potential Resources to be Developed:

- To continue to monitor this individual long-term, to do oversight and care coordination among all of the community resources above, and to work as an advocate and represent this elderly individual.

- Start a people helping people volunteer initiative to partner volunteers to assist elderly or disabled adults living in substandard housing.

- Work with the City Council to develop a neighborhood advisory group for neighborhoods with potential substandard housing and develop a matching grant fund where local businesses pay half of the costs of repair or clean-up.

- Propose the State or the Local Government to create an Emergency Housing Fund, to assist the elderly >65yr old homeowners who are facing a substandard housing crisis and meet a certain "criteria" (age, income, inability to self-manage second to mental status, education, self-care, poor social support). This will provide at risk seniors with an assigned advocate or case manager who could help them get the resources and pay on a sliding scale to help them. This Emergency Housing Fund would be non-profit and funded thru Federal/State/Local governments, local donations and/or grants. The agency would be working collaboratively with investigators or APS.

  The Advantages for the State of Implementing such an Emergency Housing Fund:

  - This program will add new jobs in the communities it serves to complete the repairs and upkeep identified in substandard housing cases
  - The new jobs generated will bring in additional tax revenue to local and State Government.
  - The repairs and cleaning of the substandard housing will improve the local housing standards
  - Defers housing depreciation to neighborhoods
  - Decrease crime and gang activity in improved housing areas
  - Total costs of this program will be less than alternatives of higher levels of cares such as nursing homes, assisted living facilities and hospitalizations secondary to substandard housing
  - The program is a non-profit and therefore, will qualify for grants and financial incentives

Appendix E.

Recognizing Elder Abuse and Neglect: A Fact Sheet for Health Care Providers

Older people today are more visible, more active, and more independent than ever before. They are living longer and in better health. But as the population of older Americans grows, so does the hidden problem of elder abuse, exploitation, and neglect. (Elder Abuse and Neglect APA Online, 2009)

Key steps in reducing the incidence of elder abuse is to recognize not only potential signs of neglect but educating people about elder abuse, increasing the availability of respite care and providing support to families with dependent adults.

Many of the symptoms listed can also occur as a result of disease conditions or medications. The appearance of these symptoms should prompt further investigation to determine and remedy the cause.

Physical

- Bruises or grip marks around the arms or neck
- Rope marks or welts on the wrist and/or ankles
- Dismissive attitude or statements about injuries
- Refusal to go to same emergency room or physician for repeated injuries
- Poor personal hygiene including soiled clothing, dirty nails and skin, matted or lice infested hair, odors, and the presence of feces or urine
- Unclothed, or improperly clothed for weather
- Decubiti (bedsores)
- Skin rashes
- Dehydration, evidenced by low urinary output, dry fragile skin, dry sore mouth, apathy, lack of energy, and mental confusion
- Untreated medical or mental conditions including infections, soiled bandages, and unattended fractures
- Absence of needed dentures, eyeglasses, hearing aids, walkers, wheelchairs, braces, or commodes
- Exacerbation of chronic diseases despite a care plan
- Worsening dementia

Emotional

- Incommunicative or unresponsive
- Unreasonably fearful or suspicious
- Lack of interest in social contacts
- Chronic physical or psychiatric health problems
- Evasiveness

Neglect

- Sunken eyes or loss of weight
- Extreme thirst
- Bed sores
- Absences of necessities such as food, water, utilities
- Animal or insect infestations
- Signs of medication mismanagement, including empty or unmarked bottles or outdated prescriptions
- Housing is unsafe as a result of disrepair, faulty wiring, inadequate sanitation, substandard cleanliness, or architectural barriers

Behavioral

Observed in the caregiver/abuser

- Expresses anger, frustration, or exhaustion
- Isolates the elder from the outside world, friends, or relatives
- Obviously lacks care giving skills
- Is unreasonably critical and/or dissatisfied with social and health care providers and changes providers frequently
- Refuses to apply for economic aid or services for the elder and resists outside help

Observed in the victim

- Exhibits emotional distress such as crying, depression, or despair
- Has nightmares or difficulty sleeping
- Has had a sudden loss of appetite that is unrelated to a medical condition
- Is confused and disoriented (this may be the result of malnutrition)
- Is emotionally numb, withdrawn, or detached
- Exhibits regressive behavior
- Exhibits self-destructive behavior
- Exhibits fear toward the caregiver
- Expresses unrealistic expectations about their care (e.g. claiming that their care is adequate when it is not or insisting that the situation will improve)

(2008, NCPEA)

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APPENDIX F.

A. National Study of Elder Abuse Statistics

Reporting:
Total number of elder abuse cases reported by year:

117,000	1986
128,000	1987
140,000	1988
211,000	1990
213,000	1991
227,000	1993
241,000	1994

Median Age:

77	Self neglect
76	Non-self neglect

Types of Abuse:

58%	Neglect
16%	Physical Abuse
12%	Financial/Material Exploitation

Race of Abuse Victims:

65%	White
21%	Black
10%	Hispanic
1%	Asian/Pacific Islanders

Sex of Abuse Victims:

22%	Male
68%	Female

Sex of Abusers:

50%	Female
50%	Male

Relationships:

15%	Other family member
14%	Spouses
34%	Outside family
37%	Adult children

Reporting Requirements:

22%	Physicians/Health Care
9%	Other Service Providers
15%	Family member
54%	Other Service Providers

B. 2008 Indiana Statistics of Elder Abuse

2008 Indiana Adult Protective Statistics

Total Calls for Service

1st quarter	13,058
2nd quarter	12,995
3rd quarter	12,974
4th quarter	unavailable

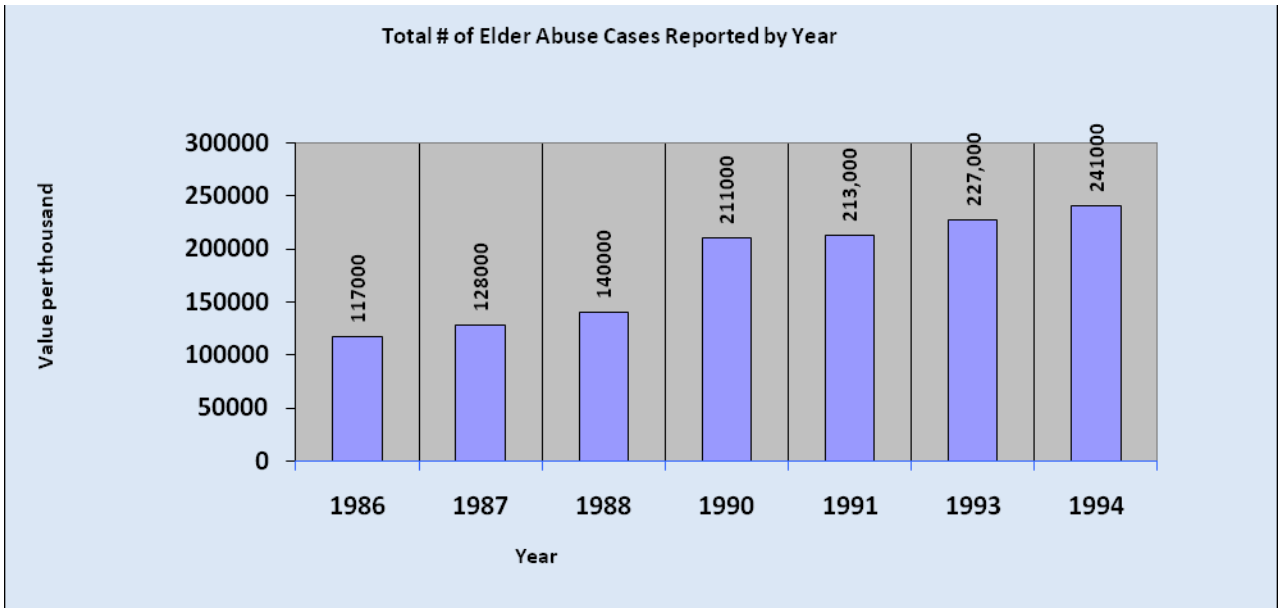
Investigations Conducted

1st quarter	4,752
2nd quarter	4,010
3rd quarter	4,053
4th quarter	unavailable

Who is Causing the Harm

Providers	32%
Self	42%
Relatives	26%

Source: (Family and Social Services Administration, 2008)



Indiana: Total number of Elderly Abuse Cases Reported to APS by year
Source: (Family and Social Services Administration, 2008)