# A Call for a Functional Multidisciplinary Approach to Intervention in Cases of Elder Abuse, Neglect, and Exploitation: One Legal Clinic's Experience

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*In their essay Ms. Levitt and Ms. O'Neill describe the frustrating work of advocating for elderly clients in a legal clinic setting. They highlight three main hurdles to effective intervention on behalf of the elderly: access to essential services, inadequate legal remedies, and procedural barriers. They argue that only a comprehensive multidisciplinary approach, involving all persons and organizations which have contact or provide services to the elderly, can guarantee that the interests and welfare of the elderly are adequately protected and provided.*

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## I. Introduction

The elderly are often among the poorest, frailest and most isolated members of our communities. Although "the elderly" include populations who are healthy, active and independent, it also includes those with limited financial resources, limited physical health, or limited competency—all of which provide ripe opportunities for physical, emotional, and financial abuse.

Although many communities have begun to recognize that elder abuse is a pervasive systemic problem, intervention in elder abuse cases is often frustratingly difficult. In fact, it is the authors' observation that advocates who work only in their traditional professional models are often the least effective interventionists. This is because the abused elderly can rarely find their way to professionals' offices alone or otherwise take advantage of resources that are available to them. Those who work with the abused elderly realize that difficulties in assisting victims of abuse stem from many factors, including isolation, in nursing homes, other institutions, and at home, from those who could assist them; dependence, often upon their abusers, for emotional and physical assistance; and inability, through dementia or other physical limitations, to seek help.

The authors of this article have spent the last several years working at the Southern Illinois University School of Law Legal Clinic for the Elderly (SIU Legal Clinic). In that work they have provided legal assistance in many situations of elder abuse. The observations made in this article come from experience with thousands of elderly clients.[1] This essay describes their observation of the problems and frustrations experienced and the steps taken to assist their clients in advocating for them.

## II. The Elderly Law Clinic

The SIU Legal Clinic is a live client law school clinic serving the elderly population in thirteen rural and southern counties of Illinois.[2] The clients of the SIU Legal Clinic are generally impoverished, isolated physically and financially, and living in depressed economic ar-

1. For a description of one of the authors' experiences assisting clients in elder abuse situations, see Suzanne J. Levitt, *The Case of the Benevolent Fiduciary: A Primer for the Unwary*, 2 CLINICAL L. REV. 523 (1996).

2. Because this article is based upon the experiences of the authors in a legal clinic located in Illinois, statutory references are limited to the State of Illinois.

eas. As a result of these circumstances, clients and potential clients, abused or not, are easily invisible.

Although there are few legal services in Southern Illinois aside from the SIU Legal Clinic, there are local advocacy agencies which provide other services to the elderly in the Clinic's service area. Many services, such as meals, home care, chore assistants, and van transportation, are theoretically available. Access to these services, however, requires that either the client requests them or the service provider knows of the need. Because the Clinic's elderly clients generally reside in secluded rural areas, the clients' (and potential clients') ability to access these resources is, at best, limited. For example, because no means of public transportation exist in most communities served by the Legal Clinic, many clients and potential clients have no means of transportation. Likewise, it is not unusual to encounter clients who have no access to a telephone.[3] There are, however, "nutritional centers" in every county.[4] Although the usefulness of the centers depends on clients' ability to access them, the centers do serve as central points from which services can be offered.

In this environment, contact with clients in their homes (through home visits, for example) is not only the most viable means of connecting clients with resources, it is also the most efficacious. The catch, however, is that there is no way of knowing when isolated individuals may need assistance. Often, the more isolated the individual, the more need exists, yet, by definition, the isolation precludes knowledge by others of that need. Although the difficulty in reaching clients or potential clients has made each advocacy organizations' work exceedingly difficult, one positive result was a general recognition that each organization had to work with others. The Legal Clinic, for example, might be contacted by a client inquiring about having a will

3. Not only do some clients have no telephone in their home, but some of the towns serviced by the clinic have only one or two pay phones, and these are located only in the central part of town. Therefore, without transportation or assistance, even access to these pay phones is beyond many of the Clinic's clients.

4. Although each county has at least one "nutritional center" (or "senior site" as they are called), each county is quite large. Therefore, although the center may be located in the largest town in the county (e.g., the county seat), this is not to say that they are centrally located nor necessarily convenient for seniors. Many centers, for example, are inaccessible during many hours of the day because they are open primarily during noon day meals. Others have physical access problems. In one county, for example, the nutritional center, although located in the county seat, is housed in an abandoned elementary school building. To access the building itself, a potential client must climb at least two flights of stairs. Obviously, this presents a barrier to seniors with disabilities.

drafted. The Clinic could then connect that client to other area organizations that could provide other services that the client might want or need, such as food, energy assistance, transportation, and the like. Likewise, a social service agency might have been contacted by a client for information about home assistance, for example, meals delivery or home care. That social service agency also could connect the client to the Clinic if legal services were needed as well.

For those clients who actually managed to contact one service or the other, this system worked well. In fact, from this somewhat haphazard interconnection of services came three very tangible realizations: (1) no organization was reaching all or even most clients, and clients who actively interacted with any organization could, if given information about other available service, often access others on their own;[5] (2) each organization came to recognize that these services could be offered in a more coordinated manner, as well as in a less formalized referral type structure; and (3) clients who most needed the services did not, would not, or could not contact any of the organizations. Victims of elder abuse most often fell into the third category.

## III. Defining the Problem

As an elder law clinic, the staff began by knowing that elder abuse is a problem which has existed for centuries[6] but which has only recently gained attention as a pervasive problem. As attention to the problem has increased, so too has a response. Yet, while every state now has programs designed to address the problem of elder abuse, reports of abuse remain alarmingly high.[7]

There are many potential reasons why reports of abuse continue to escalate. Some speculate that as public awareness of the problem grows, so does the likelihood that those who witness or experience abuse will intervene or ask for assistance. Others speculate that reports of abuse increase because abuse itself is on the rise. Although the reasons for escalating reports is uncertain, one thing is intuitively

5. Although coordination with other service organizations is certainly beneficial to this group of individuals, this can also be viewed as more of a lack of information/publicity issue. For example, Client *A*, who asked for home meal delivery from one organization might also have contacted the clinic for legal service if she had known the service was available.

6. *See* 137 CONG. REC. E3350-04 (1991) (statement of Rep. Downey).

7. Over 1.5 million older Americans are physically, emotionally, or financially abused by their own relatives each year. *See id.*

clear: once reports are made, it is important to respond to them. Experience has taught the Clinic staff, for example, that if reporters or victims of abuse perceived the situation as hopeless (or worse, if they perceived reporting or intervening in the abuse as itself increasing the likelihood that the abuse would escalate), the reports would stop or be withdrawn. Likewise, those who were already reluctant to become personally involved in what they considered to be "family matters" would discontinue reporting if they believed there would be no tangible results from the report. The authors speculated that victims who reported but saw no results would be left in a more vulnerable position than before the report was made—both by present abusers and by those whom they or their friends might not report in the future. In all, it was clear that reporting deserved not only a reaction, but deserved a reaction that was meaningful. Otherwise, the invisible would be left invisible.

Given these concerns, the Clinic staff finally realized that they really had three interconnected problems: first, they needed to reach potential clients—a problem of access. Second, they needed to assist these clients in obtaining results that made sense—a problem of remedy. Third, they needed to assist clients in utilizing the mechanisms that were already in place—a problem of process. Solutions to all of these required that they develop roles not only as legal service providers, but more importantly as liaisons. This was because they could not hope to assist victims of elder abuse without working cooperatively with others, lawyers and nonlawyers alike. Many of their clients vividly taught them this lesson. One such client was Carol.

*The Story of Carol*[8]

Carol was an eighty-five-year-old woman who had reached a point in her life when she needed basic, although not extraordinary, assistance. She lived in a small, rural town in Southern Illinois, approximately 1500 people lived there, and she had lived there all of her life. She knew most everybody, and they knew her.

Carol's husband had died several years ago. He had been a coal miner, when mining in Southern Illinois was profitable, and he had done well for himself. Carol and her husband had retired comforta-

8. The *Story of Carol* and other cases discussed here, are narratives of cases the SIU Legal Clinic handled. The authors have changed the name and changed most identifying characteristics of circumstances. They have used the essence of the stories, however, to illustrate situations which were typical for many of their clients.

bly, and even after her husband died, Carol lived quite well with the money they had put away. Because of that retirement fund, Carol did not have the worries that many of her friends had: whether her social security check would stretch through the month; whether she really needed that high priced medicine; or whether she would end up in a nursing home on public aid because she could not afford at-home help. Even without being very careful, Carol's money would last awhile. She expected it would last her lifetime.

Carol was, however, eighty-five years old and not in the best of health. She was sharp and active, but eventually she realized that she needed some help with day-to-day chores. To meet this need, Carol hired a local woman to help her out. At first, Carol had help with small chores, such as laundry, carrying the groceries, and preparing a meal or two during the week. Soon Carol began having more trouble getting about, so she asked the woman to do some errands—shopping, going to the cleaners, and maybe even making a trip or two to the bank. She only gave the woman one check at a time to use: one for the grocer, one for the dry cleaner, and one for odds and ends.

As far as Carol knew, one day she had a nice nest egg in the bank, and she did not really have too many money worries. The next thing she knew was that she did not have a dime. Carol's checks had been made out for over $100,000 and her money was gone.

By the time Carol discovered that she had no money left, she was older and more frail. The emotion she felt over the situation—the embarrassment, grief, and horror—only exacerbated her already deteriorating state. She wandered more, sometimes leaving the house but forgetting where she was going. She started to forget a lot. There was no money for home help anymore, and Carol could not care for herself alone. She ordered meals in restaurants that she could not possibly afford any longer, and she stopped going to the doctor because she did not know how she would pay the fee. In the middle of winter, she was found half-frozen on the concrete floor of a run-down room she had rented. With her situation seemingly desperate and with no one available to take her in, the local sheriff took her to a nursing home on the outskirts of town. It was presumed that Carol would stay there until she died, public assistance would pay the bill, and that would be the end of it.

Over time, however, Carol began to heal. As she received regular medication and meals, she grew stronger and more alert. Eventually, Carol decided she wanted to go home. But there was no home

anymore and no money, and the nursing home administrator told her that under those circumstances it would be unwise for her to leave. Carol needed a plan and a means to execute it.

First Carol got in touch with a social worker. The social worker told Carol that there were things that could be done. The social worker could help her find housing, she could help her get meals delivered to her door, and she could help her get medicine, get to doctor appointments, and assist her in getting someone to come in periodically to clean and do errands. The problem, Carol was told, was that because Carol now had no money, most of this assistance, which would cost money, was out of her reach. Carol was told by the social worker that it would be best if she stayed in the nursing home.

Carol next called a lawyer. The lawyer also told Carol that there were some things that could be done. The lawyer could file a lawsuit. She could represent Carol's interest before the judge and see if any of the money that was stolen could be recovered. The problem was that all of this would take time and she still had no home to go to and no way to provide day-to-day necessities. Moreover, it was not clear that a civil attorney could help her—under the circumstances, it might only be a criminal matter. Carol was told that she should probably just stay in the nursing home.

Carol's situation, like so many of the Clinic's clients, presented multiple dilemmas. One problem was reaching her. Preferably Carol and others would have been contacted before the situation reached crisis proportions. But the access problem did not end there. Once Carol was firmly in the crisis, she was further isolated by being placed out of her community into a nursing home. How then were they to reach each other?

Carol's second problem were her available remedies. Even after Carol contacted different advocates, she had no meaningful answers because no one alternative provided her with a home. By themselves, each advocate offered only partial solutions, neither of which brought Carol any closer to her goal.

Finally, Carol's problem was the process. Once solutions were offered, the question became one of whether and how they might be made available to her. Given these obstacles, the next issue was how to proceed.

### A. Defining the Access Problem

The first issue in dealing with any client is obtaining access to that client. Once the Clinic came to a concrete understanding that clients reaching them was a problem, as well as their reaching the clients, they tried to determine ways that they could resolve it. It seemed the most reasonable way for them to reach more clients was to work more closely with others in the community. Although they did this in a variety of ways, of particular note for both its positive and negative aspects, was the Multidisciplinary Team.

Like many states, Illinois has encouraged the formation of Multidisciplinary Teams, also known as M-Teams. These teams are groups of individuals from a variety of disciplines[9] who come together to generate solutions to particular elder abuse and neglect cases. It is a brainstorming session of sorts, where case scenarios are presented, the problem is discussed, and people working in different fields discuss the different ways in which a goal might be accomplished. Although the Clinic eventually began to recognize the severe limitations of these teams,[10] one particularly useful result of participation was that it was a very efficient way to interact with other community members who worked in multiple settings with the local elderly population the Clinic was trying to reach.

The M-Team and relationships like it did significantly alleviate the initial access problem. It provided a way for the Clinic to reach clients and for them to reach the Clinic which did not depend exclusively on the clients' own ability to utilize other, often complicated services. Instead, this method relied on connecting with clients through their *own* previously existing community relationships—for example, the local police officer, doctor, or Veteran's administrator. In addition, although the Clinic was establishing working relationships within a particular M-Team case, they were also establishing relationships for other future matters. In essence, they became part of the

9. For example, the team most often consisted of local law enforcement officers, elder abuse investigators, case managers, psychologists, attorneys, and physicians.

10. Among other problems encountered were these: M-Teams are designed to generate suggested alternative approaches to particular neglect/abuse situations. Although the team serves as a useful informational resource, it is not designed for any follow-through. Moreover, even if an elder abuse service provider decided to follow the suggestions of the M-Team members, there were usually few resources to secure the services suggested. These and other dilemmas, discussed *infra*, made this a less than ideal situation.

clients' existing community of associates and, at the same time, became part of the community as a whole.

For many of the Clinic's clients, this simple approach worked surprisingly well. Carol, for example, had not been their client, did not know about their services, and probably would not have been able to contact them on her own. Carol, however, did interact with other members of her community: the police officer who found her on the floor of her apartment, the nursing home administrator with whom Carol talked, the case manager who worked with Carol in the nursing home, and the doctor who performed a check-up. Although none of these individuals had any formal referral relationship with the Clinic, nonetheless informal community-based relationships existed which magnified the limited interactions Carol had.

Interestingly the very cooperative aspect of the M-Team approach which made it so appealing, too often became the obstacle which hindered its effectiveness. One of the more difficult problems encountered in this regard was each participant's own differing role as advocate and in the differing ethical obligations within those roles and to each other. Because they were working in a small community, it was not unusual for the Legal Clinic staff to participate in a supposedly confidential M-Team meeting, only to be later asked independently to represent the abused elder whose case had been discussed. Because they were the only legal service provider available, refusing representation meant that there would be none for that elder requesting it. Yet they also had participated in a meeting in which information about that client had been shared.

These and other dilemmas made the M-Team a less than ideal situation from a service perspective. Nonetheless, they and other cooperative efforts like it did help the Legal Clinic to become more visible and accessible. Access, however, was only the first problem. The problems of remedies and process still remained.

### B. Defining Problems with the Law

Because the Legal Clinic's goal was not only to make themselves available to clients in elder abuse cases, but also to obtain tangible, useful results while grappling with access problems, they began to understand the scope and limitations of the services they could offer. They began by identifying working definitions of the types of abuse and neglect encountered. These were adapted both from statutes and from the state Department on Aging's own working definitions:

*Neglect*: another individual's failure to provide, or the willful withholding from, an elderly adult the necessities of life including, but not limited to, food, clothing, shelter, or medical care.[11]

*Passive Neglect*: a caregiver's failure to provide, or willful withholding of, the necessities of life including, but not limited to, food, clothing, shelter, or medical care.[12]

*Willful Deprivation*: willfully denying a person who, because of age, health, or disability, requires medication, medical care, shelter, food, therapeutic device, or other physical assistance, and thereby exposing that person to risk of physical, mental, or emotional harm, except if the elder has expressed an intent to forego such medical care.[13]

*Abuse*: causing the infliction of physical pain or injury to an older person.[14]

*Sexual Abuse*: touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, is threatened, or physically forced to engage in sexual behavior.[15]

*Emotional Abuse*: verbal assaults, threats of maltreatment, harassment, or intimidation so as to compel the older person to engage in conduct from which he has a right to abstain or to refrain from conduct in which the older person has a right to engage.[16]

*Confinement*: restraining or isolating an older person for other than medical reasons.[17]

*Financial Exploitation*: the misuse or withholding of an older person's resources by another person to the disadvantage of the elder person and/or the profit or advantage of a person other than the older person.[18]

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11. *See, e.g.*, 320 ILL. COMP. STAT. ANN. 20/2(g) (West 1993). As discussed *supra*, because the elderly clinic in which the authors worked was located in Illinois, citations included here are to Illinois references.
12. *See* ILLINOIS DEP'T ON AGING, ELDER ABUSE AND NEGLECT PROGRAM: STANDARDS AND PROCEDURES MANUAL 2-4 (1996) [hereinafter DEPARTMENT ON AGING MANUAL].
13. *See id.*
14. *See, e.g.*, 320 ILL. COMP. STAT. ANN. 20/2(g) (West 1993).
15. *See* DEPARTMENT OF AGING MANUAL, *supra* note 12, at 2-4.
16. *See id.*
17. *See id.*
18. *See id.* at 2-5.

In the process of defining different types of abuse, it is essential to identify those to whom these definitions applied. This meant, among other things, that those who legally owed a duty of care to the Legal Clinic's elderly clients needed to be identified to determine if there was a legal remedy at all. For example, could the neighbor who continually used a client's credit card be legally said to have "abused" him? Could the daughter who failed to turn her bedfast mother so that her mother developed excruciating bedsores be said to have legally abused her? Could the son who evicted his mother after she deeded her house over to him be said to have legally abused her? The Clinic's experience with a client named Leon was typical.

*The Story of Leon*

Leon was an elderly man in his midseventies who lived alone and could pretty much take care of himself, although he was frail and very forgetful. In all, Leon was in fairly good shape, especially after he found a neighbor, a woman in her thirties, to look in on him periodically.

Leon was very happy with the arrangement he had made with his neighbor. He saw it as a friendship, because she told him that he did not need to pay her. She would bring him groceries, help him around the house, and pay his bills. In this arrangement things seemed to be going fine. In fact, as time went on and Leon's physical health deteriorated, he started to depend on her a lot. Eventually, Leon did not think he could make it without his neighbor's help.

One day his neighbor came in and asked him if he would cosign some loans for him—a major credit card, a car loan, and a Sears charge card. It was very important to Leon that the neighbor continue to help him, and because Leon liked her a lot anyway ("she was a good kid," he said), Leon said that he would. When the neighbor needed a few loans, Leon helped her out with that also. Leon did not have a lot of money, but she said she would pay it right back.

It was not very long, however, before Leon started getting bills—thousands of dollars of bills—from those credit cards. He asked his neighbor to take care of the situation, but she just stopped coming around. He could not even get his loan money back from her because she would not answer his calls. Leon did not know what to do. He was alone, scared, and now deep in debt.

The basic legal problem clients like Leon faced was that, like most states, Illinois imposes a duty of care upon only a very limited

class of people. The law does not, for example, place a duty of care upon family members who care for but do not reside with other adult family members. This is because adults are presumed to be able to make decisions for themselves and are presumed to be able to care for themselves.[19]

Strong arguments can be made favoring the exclusion of this class of people from criminal sanction. For example, the imposition of this type of legal liability upon adult children could have the effect of actually discouraging child-parent relationships. Likewise, adult children whose parents live in condition of self-neglect could be wrongfully held responsible.[20]

In many situations, however, the law can be used to intervene because a duty of care was implicitly imposed as a result of the relationship that existed. For example, a duty of care is imposed upon those who were employed to reside with an elderly person or who regularly visited to provide for health and personal care. Likewise, a duty of care is imposed upon those who had been appointed by a court to provide for the elderly person's care.[21] Statutes also imposed a duty of care upon the parent, spouse, adult child, or other relative who resided with an elderly person in certain circumstances.[22]

Although these statutes are admirable in their intent, in actual practice the authors found them to be frustratingly limited for several reasons. First, often elderly clients had been abused or neglected by people who simply fell outside the scope of either civil or criminal

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19. Criminal statutes are limited in this manner for many policy reasons which are beyond the scope of this article. For immediate purposes in the Clinic, however, the authors were not concerned with the long-term policy considerations. Instead, they were concerned with protecting individual clients who were in need of some form of intervention.

20. Although there were many reasons why policy developed as it did, the truth was that adult children of the Clinic's clients who had affirmatively abused or neglected their elderly parents were also usually beyond anyone's reach. In the staff's discussions among themselves, they speculated whether it would make more sense to modify the statutory model as it existed. That is, rather than suggesting that the criminal statute be modified to include this group of individuals, it might make more sense to suggest that a different type of duty be established for those who abuse, but who have not affirmatively taken on a caretaking role. A "duty to report," for example, has been imposed upon various individuals in other abuse and suspected abuse situations, with varying results. For the authors, however, the question was more academic than informative because, as it turned out, the criminal statutes were rarely enforced anyway.

21. For example, a duty of care is imposed by statute upon guardians. *See* 755 ILL. COMP. STAT. ANN. 5/11a-17(a) (West 1993 & Supp. 1996).

22. *See, e.g.*, 720 ILL. COMP. STAT. ANN. 5/12-21 (West 1993 & Supp. 1997).

remedies.[23] More disheartening was that even in those circumstances where a remedy was available, in the counties serviced by the Clinic, criminal statutes were rarely enforced and no comparable civil abuse statutes existed. Also, even clients who asked that such criminal statutes be enforced were usually told, as Leon was, that their problem was a "civil" matter,[24] essentially leaving them with no remedy at all.

Even when it appeared that the law actually provided an avenue of redress, its efficacy was severely restricted. For example, with Leon, a legal claim for criminal abuse existed, but the authors, as civil attorneys, could not bring it. For Carol, a legal claim for breach of fiduciary duty existed, but without her money, which could at least provide her with a home and assistance, it did not get her out of the nursing home.

What the authors saw was that there were severe limitations in the scope of laws as they existed. But this did not end the problem. Even where the law could be and was used, there were severe limitations in the process.

### C. Defining the Process Problem

Although getting beyond the access and remedy problems was no small feat, the Clinic staff often did manage it. Even then, they were far from relieved because often the process itself was the most difficult challenge their clients faced.

Once it was determined that a legal remedy might exist, the Clinic staff next encountered tremendous practical and procedural obstacles. These included: limited resources to pursue the case;[25] unco-

23. Even when the law actually provided creative possibilities for relief, the law was rendered useless because prosecutors refused to utilize it. For example, in Illinois, one criminal statute permits a victim of financial exploitation to pursue the matter civilly once a criminal charge has been filed. *See* 720 ILL. COMP. STAT. ANN. 15/16-1.3(g) (West 1993). The potential civil remedies were quite high—treble damages, attorney's fees, and costs. Unfortunately, these civil remedies could only be pursued if there was already an *underlying criminal charge*. Because the authors found it next to impossible to convince prosecutors to file criminal charges, this potentially powerful civil remedy was rendered useless.

24. This brought up many other problems as well because civil remedies were not always available in situations where criminal law applied.

25. For example, cases involving financial exploitation will often require review and presentation of checking and savings account activity, check cashing activity, withdrawal activity, and other miscellaneous activity. Simply obtaining and reviewing this information is expensive, and because it is the client's funds that have been taken, the client will usually have no money to pay for these costs. Few attorneys can take on these cases without a fund of resources to pay for this time-consuming evidence gathering process.

operative or terrorized witnesses; problems obtaining and tracing evidence; victims who had limited capacity to testify; uncooperative physicians and law enforcement officers; inability to protect the client during the progression of the case; and the confidentiality of reports of abuse that kept the identity of witnesses away from the abused elder. Furthermore, the inability to collect a judgment once one has been obtained became a problem at a case's conclusion. Although none of these problems is necessarily unique to abuse cases, the indifference to the encountered problems by those who were part of the process itself was startling. The Legal Clinic's client Anna demonstrated the problem most clearly.

*The Story of Anna*

Anna was an eighty-nine-year-old woman who lived in a home in the country. Anna's niece, Vi, who was in her midthirties, lived with Anna and claimed to be her caretaker. The nearest neighbors lived about one-half mile away from them, so no one saw them very much. Although Vi had an elementary school teaching certificate and would occasionally substitute teach at local schools, she had no real source of income. Instead, Vi lived off of her aunt's Social Security income.

Although Anna was isolated, a local agency worked with her, helping to coordinate in-home housekeeping and nursing services. This same local agency was also the state-designated agency which handled complaints of elder abuse that came in from the county. This helped because home workers spoke to them often.

As time passed, the agency began receiving numerous calls reporting that Anna was in danger. Reports indicated that Vi had been slapping Anna; Vi had punished Anna by leaving her in the bathtub for hours on end; Anna had fallen, and Vi had left her on the floor; and Vi was withholding Anna's food and water. Furthermore, Anna had been left home alone tied to a chair, and Vi, for some reason, had put a dead cat on Anna's lap on one occasion. The condition of the home itself spoke to the hazardous situation Anna was in. Papers and boxes were stacked to the ceiling with only a small path leading through the debris. Anna was in late stages of dementia—unable to respond to even the simplest questions.

The agency asked if the SIU Legal Clinic could help. If the reports were true, Anna needed to be placed in a safer situation with a guardian and out of Vi's control. Anna needed a guardian.

After visiting with Anna and verifying the conditions, Clinic staff members tried first to speak with those who had witnessed the abuse. This was no small task because the reports were purportedly confidential.[26] Once the names of the witnesses were made available, the next obstacle was to secure their testimony. This too was no small task. Some of the witnesses feared retribution from Vi. Others did not want to get involved. Even Anna's physician refused to offer his official opinion as to whether Anna was competent although it was clear that she was not.

Because none of the witnesses would voluntarily testify, they were all subpoenaed. A guardian ad litem was appointed for Anna by the court, but he had little information because he refused to talk with any of the witnesses. As a result, he had very little to offer the court. Because Anna's physician continued to refuse to offer a complete opinion about Anna's competency, it looked like Anna might simply be left where she was. If Anna was to be protected from Vi, the only alternative was to have Anna testify so that the court could observe her. But it was also clear that given Anna's condition this alternative would be traumatic and humiliating for Anna. As the abuse escalated, it became clear that there was no other choice.

The hearing itself lasted four days. Although there were eventually four attorneys involved in this case (the guardian ad litem, a court appointed attorney for Anna, Vi's attorney, and the Legal Clinic), none of them aside from the Clinic were versed in guardianship law nor experienced in handling elder abuse cases at all. In addition, the judge was reluctant to make a definitive determination, so he left Anna not particularly more protected than she had been: Vi would not be her guardian, but she retained complete access to her. It was not until some time later, when Anna was found soaked in urine after sitting for four hours in a parking lot in another state, where Vi had taken her, that this situation changed. Finally, a doctor found the courage to say that it was not safe for Anna to return to the home where Vi lived.

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26. The question of how this agency could be involved in so many different roles is important. This agency was a (1) reporting agency, (2) witness, and (3) contractor of other witnesses. In each of these roles, the agency had different obligations to Anna. In an era of limited funding, overlapping of roles is necessary. However, it can easily result in abandonment of the client when help is most needed.

For the authors, Anna's situation provided a means to reflect not only upon the legal issues involved in all of their elder abuse cases, but more importantly, it allowed them the opportunity to reflect upon many of the institutional problems typically encountered when they worked on them. Anna's case, and those like it, helped identify where the Clinic's larger community efforts were working and where great problems still existed.

## IV. Conclusion

In terms of access, the authors were shown that trying to develop relationships with potential clients' communities-of-associates was having real effect. Not only had a referral agency called the Clinic (the elder abuse agency), but Anna's own house-cleaning and home health aids had connected Anna into the system as well. Thus, some of the only individuals to whom Anna had access became her eventual tie to the Clinic. Unfortunately, the vision of working within the community-of-associates was not universally successful. Anna's doctor, for example, also observed and interacted with Anna. Yet, not only did he fail to provide her with assistance, he actually refused to involve himself until he was forced to do so by court order. Even then, he demonstrated that he had little understanding of the problems that his patients like Anna encountered.

With regard to remedies, Anna's situation provided a means to observe the potential and the deficiencies of the laws with which the Clinic worked. The guardianship proceeding, for example, eventually proved to be a viable and effective tool in protecting Anna. Likewise, the elder abuse reporting system had worked. Because Vi had no assets of her own, however, there was no further civil remedy available, and despite the eventual findings of the judge in the guardianship proceeding, Vi's later actions in leaving Anna in another state, Vi was not prosecuted for elder abuse.

Finally, with regard to the process, the authors discovered it eventually did work, but not as easily as it could have. During each step of the proceeding, something was amiss, including the guardian ad litem's lack of understanding about his role, Anna's physician's belief that he need not participate, the home-care workers' refusal to tell what they knew, and the judge's discomfort with making a difficult decision. As a legal clinic, the staff was invariably forced to confront squarely not only the economical and emotional cost that

situations like this might pose to private attorneys, but to also question whether more harm than good might result from subjecting clients to this process at all—a process replete with unfulfilled potential in which it was both difficult and painful to participate.

In the end, experiences with Anna, Carol, Leon, and many other clients forced examination of how far the Clinic still needed to go before they could say they were obtaining meaningful results for victims of elder abuse. Often they found unwilling witnesses, uncooperative physicians, attorneys who had no understanding of their roles in the process, state's attorneys who referred cases to them for "civil" relief, and courts who were unwilling to take responsibility for their decisions. As a legal clinic, they often felt burdened by the responsibility placed upon them to try and come up with good solutions for the abused elderly when just as often no good solutions existed.

Nonetheless, there were signs of progress. Although efforts at working within the community reaped far from ideal results, the authors came away from it having a better understanding of its limitations. More importantly, despite the limitations, they helped many clients in the process. In doing so, they began to come to understand that viable alternatives do exist, and the means to implement those alternatives are often already in place.

It is clear from the authors' experiences that the elderly in southern Illinois would be far more vulnerable to exploitation and abuse if it were not for a program funded to provide legal services to the elderly. The situations of abuse and exploitation are frequently not the type of cases that prosecutors choose to prosecute whether it is because the victims frequently cannot or will not testify against the abuser or some other reason. Despite intervention from service providers to the elderly, abusive situations frequently continue until legal intervention causes the abuse to stop. Private attorneys cannot be expected to commit the time and resources that such cases demand for effective intervention.

The legal service provider for the elderly must be connected to service providers, police officers, clergy, medical providers, and others who are traditionally called upon to serve in the multidisciplinary approach to problem solving for elderly. The solutions to elder abuse most often do not result from legal processes but from coordinated community response. Without knowledge and access to the community resources, legal counsel cannot be completely effective.

It is equally clear to best serve clients' needs, the legal clinic must also be separate from the service providers for the elderly. Without separation, there could be no independent attorney-client relationship. Such a relationship is needed to gain the client's trust, for the client to feel that his interests are being protected, and for the client to feel that his private affairs remain confidential.

Unless a legal service provider continues to take hard cases through the painstaking legal process, even though the remedy often may not seem meaningful, elder abuse will continue to flourish. One must remember that elder abuse is often stopped through the process and hope that the efforts make some impact on diminishing future abuse.