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AN ADVOCATE'S GUIDE TO LAWS AND PROGRAMS ADDRESSING ELDER ABUSE

AN INFORMATION PAPER

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PREFACE

Elder abuse is a complex problem whose incidence, causes and remedies remain the subject of controversy among various advocates for the elderly. It is a phenomenon which encompasses different types of behavior—violence, neglect, exploitation—and occurs in a variety of settings including private homes, nursing homes, board and care facilities, and hospitals.

Of special concern to Federal policymakers are the difficulties associated with the development of national statistics on the victims of elder abuse. Data on abuse victims are not collected or reported in a uniform way from jurisdiction to jurisdiction and state to state. This makes it exceptionally difficult to evaluate the need for national legislation and funding for elder abuse. Later, the absence of comparable data also makes it difficult to determine whether Federal funding to reduce the incidence of elder abuse—through research, or public education, or intervention has made a true impact upon the problem. The various contributors to this print strongly recommend the development of uniform data gathering and reporting methodologies to better reveal the national dimensions of the problem of elder abuse.

We are pleased to make this report available to those who counsel, advise, and advocate for older persons. Lawyers, physicians, and other health care professionals, clergy, social workers, and many others are in key positions to observe and to contribute to the remedy of elder abuse.

We extend our sincere appreciation to the author, Marcia Libes Simon, Esquire. Her knowledge of and sensitivity to the rights of the elderly are clearly reflected in this important monograph. Special thanks are due to various others who contributed to the writing and production of this print. Committee Investigator Kate Kellenberg authored sections on ethnic and language minority elders, and with the assistance of Anna Kindermann, Ann Trinca, and Ann Arnof Fishman of the Aging Committee staff, served as print editor. The Committee also wishes to thank Debra Broughton, National Aging Resource Center on Elder Abuse, Washington, D.C., and Professor Susan Tomita, School of Social Work, University of Washington, for contributing materials and invaluable guidance to Committee staff.

Through sharing what we know of this problem, we sincerely hope to contribute to the elimination of the stigma and the silence surrounding the issue of abuse. The terrible indignity of elder abuse and neglect needs to be voiced, strongly and clearly, in various languages, in all communities, until the pain caused by this abuse has been relieved.

DAVID PRYOR,
Chairman.
WILLIAM COHEN,
Ranking Minority Member.

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SECTION I. INTRODUCTION

Congressional attention first turned to the problem of elder abuse more than a decade ago, but the Federal Government has been criticized for failing to take decisive action in adopting policies and programs to combat elder abuse, and for failing to allocate funds for such efforts when policies have been devised. The States have adopted a myriad of laws designed to deal with elder abuse, but the effectiveness of these laws and the assumptions upon which they are based is currently in question.

To best protect actual and potential elder abuse victims, it is essential to examine various issues: What is elder abuse in all of its destructive forms? What is known and what remains to be learned about why and to whom it occurs? What laws and other methods of intervention are available to advocates for the protection of victims and at-risk elders? How do cross-cultural factors enter into the choice of intervention styles? What may be done to bring legal action against abusers? What future developments in Federal policy will be required to address deficiencies in the system to protect the abused elderly?

This report will address each of these issues, *with an emphasis on the Federal and State laws which may serve as tools for those working on behalf of the abused or at-risk older persons.* While the legal system is available to advocates for the abused, most applicable laws suffer from one or more of the following deficiencies:

1. **Inappropriate assumptions underlie many statutes.** For example:

   Much adult protective services (APS) legislation is based on the assumption that vulnerable adults lack the ability to make decisions about their own care and lifestyle. As a result, well-intentioned APS workers may impose services on abuse victims against their will. This is because APS laws have in general been modeled after child protective services legislation. In fact other approaches, such as those which strengthen the victim, may be more appropriate.

   Policymakers have proceeded under the assumption that caregiver stress is a leading cause of elder abuse. While this popular notion has some validity, researchers are far from certain that caregiver stress is a major cause of abuse. In fact, recent studies suggest that the abuser's personal problems and his or her dependence on the elder are more likely to be precipitating causes of abuse.

2. **To the extent that caregiver stress can result in abuse, Federal programs are grossly inadequate for elders best served by quality home and community-based care.** Without access to affordable, high quality home and community-based care, a disabled elderly individual may have no choice but to remain under the care of an

unpaid caregiver (typically a relative) who may become abusive due to the financial, emotional, and physical burdens of caregiving. Federal programs, however, offer little support for home and community-based care. For example:

Medicare and Medicaid provide reimbursement for home and community-based care only under the most limited of circumstances; and

The Social Services Block Grant and Older Americans Act (OAA) programs, two important Federal funding sources for nonmedical home and community-based care, do not impose quality standards on providers.

3. **Lack of a coherent legislative philosophy results in inconsistent laws. Inconsistent laws, in turn, present a number of problems, including the following:**

States' mandatory reporting laws stand in direct conflict with the confidentiality requirements of the long-term care ombudsman program; and

Interventions to protect an abused elder result in a deprivation of his or her autonomy and rights, such as removal from the home and institutionalization.

4. **Laws to prosecute abusers carry built-in disincentives to proceed with litigation and may offer no real remedy for the victim.** Examples include:

A damage award in a tort action terminates an elder's Medicaid eligibility.

The perpetrator of abuse is sent to jail as a result of a successful criminal prosecution, and the elder loses his or her only caregiver.

5. **Important Federal legislation in the elder abuse arena has received insufficient funding, weakening its impact.** Examples include:

The OAA's long-term care ombudsman program, which has received inadequate funding to pursue its statutory mandate to investigate abuse in board and care facilities; and

The OAA's elder abuse prevention provisions were only recently funded (FY 1991) at $2.9 million, although the authorization for funding of State-level prevention activity was granted in 1987. Once the current funding is divided between the 670 area agencies on aging, the awards will be too small to support significant prevention activities.

This report reviews the nature of elder abuse—its incidence, forms, and causes. It then identifies existing laws that relate to the problem of elder abuse, analyzes their benefits and shortcomings, and proposes a research and policy agenda that may provide a blueprint for finding better solutions to this pressing national problem.

SECTION II. THE NATURE OF ELDER ABUSE: TYPES, INCIDENCE, AND CAUSES

There is much conflicting information regarding the nature of elder abuse—the frequency with which it occurs, its causes, and the characteristics of its victims and perpetrators. To muddy the already murky waters, definitions of elder abuse vary from one statute to the next and from one researcher to another. In fact, the one thing that may be said with certainty about the nature of elder abuse is that more needs to be known.

A. DEFINITIONS OF ELDER ABUSE

While researchers have used different definitions of elder abuse in conducting their studies, it is generally accepted that the following behaviors constitute elder abuse:[1]

Physical abuse. Physical abuse is violent conduct which results in the infliction of pain or bodily harm. Hitting, slapping, sexual molestation, physical coercion, inappropriate use of physical or chemical restraints, and burning are among the many different types of actions that constitute physical abuse. Injuries can range from scratches, cuts and bruises, to fractures, severe burns, paralysis, and death.

Restraints have been routinely used in institutions as a safety device (i.e., to prevent a disabled person from falling), as a substitute for insufficient staff, and to prevent liability. Within the last couple of years, however, there has been a tremendous effort to reexamine providers' use of restraints: "Spurred by new Federal regulations discouraging the use of physical or chemical restraints[2] and by a changing view of what is good medical practice, a consensus is emerging that far too many institutionalized elderly people are being restrained."[3]

Psychological abuse. Psychological or emotional abuse is behavior that induces mental anguish. It may consist of a caregiver's threats to harm or institutionalize the elder, name calling, intimidation, or isolation. Psychological abuse can cause a wide range of responses, including shame, confusion, fearfulness, depression, nervous disorders, and, in extreme cases, suicide.

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[1] In *Elder Abuse: A Decade of Shame and Inaction,* Comm. Publ. 101-752, 101st Cong., 2nd Sess. (Apr. 1990), the Subcommittee on Health and Long-Term Care of the House of Representatives Select Committee on Aging sets out numerous case studies that illustrate each type of abuse and neglect.

[2] These are discussed in Part IV-B-2 of this report.

[3] Lewin, T., "Nursing Homes Rethink Merits of Tying the Aged," The New York Times, December 28, 1989. *See Untie the Elderly: Quality Care Without Restraints, Symposium before the U.S. Senate Special Committee on Aging,* S. Prt. 101-90, 101st Cong., 1st Sess. (Dec. 4, 1989); Johnson, S.H., "The Fear of Liability and the Use of Restraints in Nursing Homes," *Law, Medicine and Health Care,* Vol. 18, No. 3 (fall 1990), pp. 263-273.

Financial abuse. Financial abuse is theft or conversion of money or other valuables by an elder's relatives or caregivers. It can range from stealing small amounts of cash to inducing the elder to sign away bank accounts or to deed away real property. Financial abuse can occur through force (e.g., by gunpoint), fraud, or unfulfilled promises of lifetime care in exchange for deeding over assets.

Active neglect. Active neglect is the intentional failure to fulfill a caretaking obligation necessary to maintain the elder's physical and mental well-being. Deliberate abandonment, intentional denial of food or health-related services, and depriving the elder of dentures or eyeglasses constitute forms of active neglect.

Passive neglect. Passive neglect is the unintentional failure to fulfill a caretaking obligation. It is neither a conscious nor a willful attempt to inflict physical or emotional distress. A caretaker's own infirmity, ignorance about the importance of prescribed services, or competing responsibilities may result in passive neglect.[4]

Self-neglect/self-abuse. Self-neglect and self-abuse refer to situations in which an individual fails to provide himself or herself with the necessities of life, such as food, clothing, shelter, adequate medication, and reasonable management of financial resources. The consequences may include poor grooming and eating habits, severe health problems, or death. Self-neglect can also result in the unreasonable wasting of financial assets. The concepts of self-neglect and self-abuse are controversial. They have been criticized on the grounds that they do not represent an elder abuse problem, but are a result of society's failure to respond to the needs of the elderly. Moreover, while such behavior may result from impaired mental and physical capabilities, it may also be a result of poverty, drug, or alcohol abuse, or the lifestyle choice of a competent but eccentric individual. It has been estimated that a little more than half of the reported cases of elder abuse are in fact cases of self-abuse and self-neglect.[5]

B. PREVALENCE OF ELDER ABUSE

While the prevalence of elder abuse is not known with certainty, it is widely agreed that the problem affects a significant number of older persons. A 1990 report by the Subcommittee on Health and Long-Term Care of the House of Representatives Select Committee on Aging reported that 1 out of 20 older Americans, or more than 1.5 million persons, may be victims of abuse each year.[6] The National Aging Resource Center on Elder Abuse (NARCEA) estimates that 2 million reportable cases of elder abuse occurred in 1988 in domestic settings alone.[7] A study conducted in the metropolitan

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[4] When a caregiver's religious beliefs result in his or her failure to meet an elder's medical needs, it raises the question of whether active or passive neglect has occurred. While there is an intentional failure to carry out a caregiving task, there is no intention to inflict harm.

[5] The National Aging Resource Center on Elder Abuse estimates that "55 percent of the reported cases in 22 states during 1988 were determined to be self-neglect or self-abuse cases." Estimates of the percentage of incidence in 24 States in 1988, excluding self-abuse and neglect, include: neglect 37.2%, physical abuse 26.3%, financial exploitation 20%, emotional abuse 11%, all other types 2.8%, sexual abuse 1.6% and unknown 1.1%. *Elder Abuse: Questions and Answers, An Information Guide for Professionals and Concerned Citizens,* National Aging Resource Center on Elder Abuse (NARCEA), Washington, D.C., June 1991 [Second Edition], pp. 5–6.

[6] *Elder Abuse: A Decade of Shame and Inaction,* p.xl.

[7] National Aging Resource Center on Elder Abuse, *Summaries of National Elder Abuse Data: An Exploratory Study of State Statistics* (Washington, D.C: 1990), p. vii.

Boston area revealed that 32 per 1,000 individuals age 65 and older residing in the community at large suffer from physical abuse, verbal aggression, and/or neglect.[8] If a national survey yielded similar results, these findings could represent 701,000 to 1,093,560 victims per year, *excluding* victims of financial abuse, self-abuse, and self-neglect. It is often said that the number of abused elders is growing, but there is little hard data to support this belief.[9]

While there are no national statistics on the incidence of elder abuse in institutions, a recent study suggests that elder abuse is a fact of institutional life. In this study, 40 percent of the nursing home staff surveyed admitted to personally committing at least one psychologically abusive act in the preceding year, and 10 percent admitted to physically abusing residents.[10]

C. CHARACTERISTICS OF VICTIMS AND ABUSERS

The typical elder abuse victim is a woman of poor to modest means over 75 years of age. She is generally widowed, living with relatives, and frail and vulnerable due to physical and/or mental disabilities.[11]

The perpetrator of abuse is likely to be an adult child who acts as the elder's caregiver.[12] In general the abuser is middle aged, unless he or she is a spouse or a grandchild.

D. CAUSES AND CONTRIBUTING FACTORS

Many different theories have been proposed to explain why elder abuse and neglect occur. Depending on the type of abuse or neglect and the setting where it occurs, certain causes may be more or less likely than others.

Some of the more significant and commonly cited theories of why abuse occurs in the *domestic setting* include:

1. **Caregiver stress.** The notion of the stressed caregiver, burdened by the emotional and financial strains of caring for an impaired and dependent elderly person, has received much attention. The view is that the caregiver cannot cope with these pressures and becomes abusive. This theory, which is based largely on anecdotal evidence, has been criticized because there are few firm research findings which support it. Moreover, there is preliminary

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[8] Pillemer, K. and Finkelhor, D., "The Prevalence of Elder Abuse: A Random Sample Survey," *The Gerontologist*, Vol. 28, No. 1, pp. 51-57 (1988).

[9] NARCEA estimates that 1.6 million "reportable" domestic elder abuse incidents occurred in 1986, and that this number rose to 1.8 million and 2.0 million in 1987 and 1988, respectively. *Summaries of National Elder Abuse Data*, p. 10. According to the Subcommittee on Health and Long-Term Care of the House of Representatives Select Committee on Aging, roughly 1 million older individuals were abused in 1980, and at present approximately 1.5 million elders are abused annually. *Elder Abuse: A Decade of Shame and Inaction*, p. x-xi.

[10] Pillemer, K. and Moore, D., "Abuse of Patients in Nursing Homes: Findings from a Survey of Staff," *The Gerontologist*, Vol. 29, No. 3, pp. 314-320 (1989).

[11] *Summaries of National Elder Abuse Data*, pp. 18-19; Quinn, M. and Tomita, S., *Elder Abuse and Neglect: Causes, Diagnosis and Intervention Strategies* (New York: Springer Publishing Co., 1986) (hereafter Elder Abuse and Neglect), p. 31; Wolf, R. and Pillemer, K., *Helping Elderly Victims: The Reality of Elder Abuse* (New York: Columbia University Press, 1989), p. 32.

[12] A survey of 15 States in 1988 revealed that abusers were most frequently adult children 30%, other relatives 17.8%, spouse 14.8%, service providers 12.9% and friends/neighbors 10.0%. *Elder Abuse: Questions and Answers*, p. 7.

evidence that the main risk factor is the abuser's dependence, not the victim's.[13]

2. **Dependence of the abuser.** Many abusers are dependent to a significant degree—financially or otherwise—on their victims. Abuse then occurs in response to a perceived powerlessness vis-a-vis the elderly individual. The abuser's dependence on the older person may be due to conditions such as mental illness, developmental disability, or drug or alcohol use.

3. **Elder's physical and mental impairment.** Most abused and neglected elderly individuals are physically and/or mentally impaired. Their inability to carry out the tasks of daily life makes them vulnerable and dependent on caregivers. While not in itself a cause of elder abuse, this is often a contributing factor.

4. **Learned violence.** It is commonly believed that domestic violence, whether child or spousal abuse, is learned in the home and passed from generation to generation. Thus, it would appear that those who abuse the elderly were raised in homes where domestic violence occurred. When the abuser is an elderly individual's adult child, there is the added element of retaliation (conscious or otherwise) against the person who abused him or her as a child.

5. **Pathology of the caregiver.** In many cases, the abuser has a serious disabling condition such as drug or alcohol addiction, a sociopathic personality, psychiatric problems, mental retardation, or dementia.

6. **Societal attitudes.** While not causes in and of themselves, certain societal attitudes contribute to elder abuse and neglect. Among these are ageism, which is stereotyping of and discrimination against the elderly because they are old; negative attitudes toward the disabled; greed by those who hope to inherit or benefit from the older person's estate or assets; and sexism, which is significant because a disproportionate number of abused elderly persons are women.

7. **Social isolation.** Families with a pattern of violence are more likely than others to be socially isolated. Their behavior is hidden from scrutiny by those outside the family unit or immediate community. Given this, it is not surprising that socially isolated elders are more likely to be abused than those with an extended social support network.

8. **External stress.** Research in the areas of child and spousal abuse suggests that stress unrelated to the relationship where abuse occurs—for example, financial difficulties, competing family responsibilities, or problems at work—can result in abusive behavior.

Other theories seek to explain why abuse or neglect occur in *nursing homes:*

1. **Staff characteristics.**[14] Staff members who are young, poorly educated, and inexperienced in nursing home work are more likely than others to have negative attitudes toward the elderly and to commit abuse. Studies have found that nurse aides are more likely

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[13] Pillemer, K. and Finkelhor, D., "Causes of Elder Abuse: Caregiver Stress Versus Problem Relatives," *American Journal of Orthopsychiatry*, Vol. 59, pp. 179–187 (1989).

[14] Pillemer, K., "Maltreatment of Patients in Nursing Homes: Overview and Research Agenda," *Journal of Health and Social Behavior*, Vol. 29, pp. 227–238 (1988).

to be abusive than nurses. High levels of stress and burnout can also lead to abuse.

2. Facility characteristics. Abuse is more likely to occur in facilities with a high staff turnover rate, low staff-to-patient ratios, a custodial environment, and relatively low patient expenditures.[15]

3. Resident characteristics. Residents who are physically or mentally impaired, socially isolated, and female are more likely than others to suffer from abuse.[16]

Board and care facilities are another setting where elder abuse is believed to be pervasive.[17] Information from State surveys suggests that the board and care population has a number of characteristics that render it especially isolated and vulnerable:

> [T]he board and care industry serves many individuals who have physical limitations; have previously lived in an institution due to a mental disability, are unlikely to have friends or relatives visit them, and have low incomes. Because so many of these individuals are alone, they have no one to look out for their interests if they are mistreated, abused, or receiving poor quality care in a home.[18]

The 1972 enactment of the Supplemental Security Income (SSI) program, which provides income for the indigent aged, blind, and disabled, created the financial incentive for board and care home operators to open their doors to the mentally ill, the poor, and others who are significantly disadvantaged.[19] However, SSI payments (sometimes augmented by a State supplemental payment) generally fail to meet providers' costs. This may result "in providers' cutting corners by lowering the thermostat, reducing staff, substituting less nutritious food, or simply providing less food, and generally failing to meet residents' material and care needs."[20]

Residents' needs are further compromised by the minimal skills and training of providers and staff and a deteriorating physical plant.

CONCLUSION

The reasons why elder abuse occurs have profound significance for policymakers. If the caregiver stress model has validity, then nonmedical in-home services for the elder and enhanced respite and social support for the caregiver at-risk may serve to reduce the stress that results in abusive or neglectful behavior. If elder abuse bears a greater resemblance to spousal violence than to child abuse, then the focus should be on strengthening, rather than protecting, the victim. If social isolation plays a significant role in contributing to elder abuse, outreach programs and social support

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[15] *Id.*, pp. 231-232.

[16] *Id.*, p. 233.

[17] *See, e.g.*, House of Representatives Select Committee on Aging, Subcommittee on Health and Long-Term Care, *Board and Care Homes in America: A National Tragedy*, Comm. Pub. No. 101-71, 101st Cong., 1st Sess. (Mar. 1989); Government Accounting Office, *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met*, GAO/HRD-89-50 (Feb. 1989).

[18] *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met*, p. 39.

[19] It is believed that over 72% of the board and care home population relies on SSI for the entirety of their income. *Board and Care Homes in America: A National Tragedy*, p. ix.

[20] The National Center for State Long Term Care Ombudsman Resources and the National Association of State Units on Aging, *A Study of the Involvement of the State Long Term Care Ombudsman Programs in Board and Care Issues* (Washington, D.C.: 1989), pp. 3-4.

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groups may play a preventive role. Counseling for abusers may also be helpful if the theories of abuser dependence and pathology are substantiated. It is also important to understand why elders with other options sometimes stay in abusive or threatening situations, for this raises the question of whether they will seek assistance and alternative living arrangements if these become more widely available.

To allow policymakers to design the most effective measures to deal with elder abuse, funds need to be allocated to support research into the causes of abuse, and efforts need to be made to collect data consistently on elder victims and their abusers.

SECTION III. OVERVIEW OF LAWS

At the State level, elder abuse is treated differently from one jurisdiction to the next. In the most recent study of its kind, the American Public Welfare Association (APWA) and the National Association of State Units on Aging (NASUA) conducted a comprehensive analysis of State policy and practice on elder abuse in 1986.[21] At that time, 48 States had legislation dealing with elder abuse.[22] Their laws fell into the following categories:

- 10 States dealt with the problem through elder abuse-specific laws
- 20 States addressed elder abuse exclusively through adult protective services (APS) laws
- 17 States used more than one type of law
  - California used elder abuse-specific and adult protective services (APS) laws;
  - 16 States used either an elder abuse-specific law or an APS law as the main State statute for elder abuse, and provided additional coverage through a variety of other statutes, including (a) laws protecting residents of long-term care facilities; (b) laws relating to institutional abuse; (c) domestic violence statutes; and (d) a patients' bill of rights; and
  - Michigan dealt with elder abuse through its social service legislation.

To further complicate matters, State legislation regarding elder abuse is constantly changing. At the time of the APWA/NASUA study, 22 States indicated that they were considering new or additional elder abuse-specific legislation or amendments to their existing statutes.[23]

There are other kinds of State law that are highly important to advocates for abused and at-risk elders. These include laws governing the use of legal planning devices such as durable powers of attorney and joint property arrangements; criminal statutes under which abusers may be prosecuted; licensure requirements for care providers; and tort law.

At the Federal level, the problem of elder abuse is treated directly and indirectly through:

- Social Services Block Grant funding for APS programs and home and community-based care;

[21] American Public Welfare Association and the National Association of State Units on Aging, *A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse* (Washington, D.C.: 1986), pp. 7-12.

[22] Since that time, the two States without laws addressing the problem of elder abuse (North Dakota and Pennsylvania) have passed pertinent legislation.

[23] *A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse*, p. 13.

- Federal nursing home requirements, including the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987, as amended in 1988–90;
- Medicare and Medicaid fraud and abuse statutes;
- quality of care requirements for home health agencies;
- Older Americans Act programs, including the long-term care ombudsman program, home and community-based care services, legal services, and elder abuse prevention services;
- Medicare and Medicaid home care benefits; and
- representative payee programs.

In assessing these laws, it is useful to view them as having three interrelated aspects:

- *protection* of the abused or at-risk elder;
- *prevention* of elder abuse; and
- *prosecution* (civil and criminal) of the abuser.

These categories will be used to analyze laws and to assess their benefits and shortcomings.

SECTION IV. PROTECTION

A. ADULT PROTECTIVE SERVICES

Virtually every State has an adult protective services (APS) law which provides a centralized system to (a) receive reports of abuse and neglect, (b) investigate reports, (c) intervene through the delivery of services to the victim, and (d) impose supervision and services to assist the nonconsenting abused elder who may lack capacity. In the vast majority of jurisdictions, APS agencies are authorized to protect abuse victims in institutional and congregate living settings, as well as individuals residing in the community at large.[24] The APS agency is typically located within a State human services agency, and in most jurisdictions the county department of social services maintains an APS unit serving the needs of the local community.[25]

Professor John Regan, a preeminent scholar of APS legislation, describes thus the legal underpinnings of these laws:

> Adult protective services programs are circumscribed by the legal authority of an intervenor to impose a decision on an unwilling individual. The Anglo-American legal system traditionally has authorized such intervention through either civil commitment or guardianship proceedings. Grounded in the State's police power, civil commitment proceedings affect persons adjudged to be dangerous to others or to themselves as result of mental illness. These individuals are sent, either by the signed order of two or three physicians or by court order, to a State mental hospital for care and treatment. The guardianship procedure, resting on the State's *parens patriae* power, enables a court to appoint a surrogate decisionmaker for persons found to be incompetent.[26]

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[24] Depending on State law, APS agencies investigate and provide services for abuse and neglect victims in licensed nursing homes, personal care homes, residential care homes, board and care facilities, adult foster care/family homes, State mental health/mental retardation facilities, room and board homes, medical facilities or hospitals, and unlicensed facilities. National Association of State Units on Aging and the American Public Welfare Association, *Adult Protective Services: Programs in State Social Service Agencies and State Units on Aging* (Washington, D.C.: 1988), pp. vi, 60-69, 179-190.

[25] National Aging Resource Center on Elder Abuse, *Elder Abuse: Questions and Answers, An Information Guide for Professionals and Concerned Citizens* (Washington, D.C.: 1990), p. 13.

[26] Regan, J., "Protecting the Elderly: The New Paternalism," 32 *Hastings Law Journal* 1111, 1113-1114 (1981). An earlier piece by Professor Regan, *Protective Services for the Elderly: A Working Paper,* Senate Special Committee on Aging, 95th Cong., 1st Sess. (Washington, D.C.: 1977) remains an essential resource on the nature of APS programs.

1. Trends

In recent years, certain trends have been evident in APS legislation: [27]

For better or for worse, there has been an overwhelming trend toward laws mandating certain professionals (and in some cases the general public) to report suspected cases of abuse, neglect, and exploitation. At present, 42 States and the District of Columbia have mandatory reporting laws. Prior to 1980, only 16 States mandated the reporting of elder abuse.

In 1989, North Dakota, Hawaii, and New Mexico increased to 34 the number of States to adopt APS legislation that applies to all adults, not just the elderly. While such legislation recognizes the fact that not just the elderly require protection from abuse and to avoid allegations of ageism, in practice nearly 70 percent of APS agencies' caseloads involve elderly victims. [28]

Virtually every State's APS law provides a mechanism for involuntary intervention when there is an objection by the vulnerable adult or the caregiver, or when the vulnerable adult is not capable of consenting. Interventions may include appointment of a guardian or conservator, provision of appropriate treatment, or removal of the elder from the care of an abusive or neglectful caregiver.

A few States have recently added criminal penalties (i.e., fines and imprisonment) to their protective services legislation.

Many State laws limit the effect of a guardianship by providing that appointment of a guardian is not a finding of general incompetency for all purposes, and does not create a presumption of incompetency. Thus, the ward retains all rights not specifically removed by court order.

An increasing number of States recognize in law (if not in actual practice) the concept of limited guardianship, in which a court limits the surrogate's authority to matters beyond the ward's ability to decide. The statutes may also authorize the court to make a decision for an individual rather than appoint a guardian. This stands in stark contrast to earlier statutes which authorized general or plenary guardians, leaving the ward with no right to decide about personal or property matters.

More States are removing "advanced age" from the list of indicators for incapacity. In fact, many States have moved from categorical to functional definitions of incapacity.

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[27] Legal Counsel for the Elderly, "1990 Adult Protective Services Legislation"; Legal Counsel for the Elderly, *Decision-Making, Incapacity, and the Elderly: A Protective Services Practice Manual* (1987), p. 67 (hereafter *Protective Services Practice Manual*); Coleman, N. and Karp, N., "Recent State and Federal Developments in Protective Services and Elder Abuse," *Journal of Elder Abuse & Neglect*, Vol. 1, No. 3 (1989), pp. 51–63; Wang, L., Burns, A., and Hommel, P., "Trends in Guardianship Reform: Roles and Responsibilities of Legal Advocates," *Clearinghouse Review*, Vol. 24, No. 6 (Oct. 1990) (hereafter "Trends in Guardianship Reform").

[28] *Elder Abuse: Questions and Answers, An Information Guide for Professionals and Concerned Citizens*, p. 14.

2. Reporting Laws

A highly charged issue in the APS arena is whether the reporting of suspected cases of abuse and neglect should be made mandatory or voluntary.[29] Despite considerable arguments against mandatory reporting laws, 42 States and the District of Columbia have statutes which make reporting mandatory for professionals or other individuals likely to encounter cases of elder abuse. Mandatory reporting is not universal, and voluntary reporting is allowed in some jurisdictions. Three of the last States to adopt reporting laws (North Dakota, Illinois, and Pennsylvania) have made reporting voluntary.

These laws vary widely in defining the categories of people required to report. Those generally required to report include social workers, law enforcement officers, doctors, surgeons, nurses and clergy.[30] Some States expand this category to include all persons who know or have reason to suspect that elder abuse has occurred. Mandatory reporting laws generally grant immunity to those who make good faith reports, and employees are given statutory protection against employer retaliation.[31]

While failure to report is usually a misdemeanor, under some statutes the penalty may be a fine or imprisonment.[32]

Reports are made to a State, regional, or local agency which investigates. These are generally State social service departments, but in some States they are law enforcement agencies or the long-term care ombudsman's office.[33]

Those who support mandatory reporting state that such laws heighten awareness of the problem of elder abuse among those who are required to report. It has been established that more cases of elder abuse are reported as a result of these laws. However, this does not imply that reporting laws effectively reduce the amount of elder abuse. A recent GAO survey of State level APS and aging agency officials indicates that reporting laws are less effective than other factors in the actual prevention of elder abuse. Reporting laws were ranked seventh out of eight possible factors following in-home services for the elderly, public and professional awareness, in-home respite care, community-based support services, counseling services and interagency coordination. Only the effectiveness of penalties for abusers ranked below.[34] Another study revealed that since mandatory reporting became the law in Washington State, there has been an increase in the number of clients referred to the State's APS program who were subsequently found to lack psycho-

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[29] The following materials provide an overview of the mandatory reporting controversy: Faulkner, L., "Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults," 16 *Fam. L. Q.* 69 (1982); Katz, K., "Elder Abuse," 18 *Journal of Family Law* 695, 711–715 (1979–80); *Protective Services Practice Manual*, p. 86.

[30] *A Comprehensive Analysis of State Policies and Practice Related to Elder Abuse*, pp. 115–124.

[31] *Id.*, pp. 146–147.

[32] *Id.*, pp. 143–144.

[33] *Id.*, pp. 65–70, 128–130.

[34] *Elder Abuse: Effectiveness of Reporting Laws and Other Factors*, Report to the Chairman, Subcommittee on Human Services, Select Committee on Aging, House of Representatives, April 1991.

logical or physical problems.[35] Such unsubstantiated reports draw upon APS programs' limited resources, making it difficult for them to function efficiently. This raises the related question of whether mandatory reporting alerts APS agencies to the most serious cases of abuse and neglect, or whether these cases remain hidden in homes and other settings.

Mandatory reporting requirements are modeled after child abuse reporting laws.[36] This approach, however, fails to recognize the difference between the social and legal status of childhood and adulthood. Our legal system presumes that children lack competency and require protection against their own helplessness. In return for protection, children are denied rights and powers granted to competent adults. As adults, the elderly are entitled to privacy and personal autonomy, but mandatory reporting presumes that they need to be protected against themselves and others who intrude upon their privacy. It has been suggested that methods used to combat spousal abuse—advocacy and supportive services that strengthen the victim and the family unit—may be a better model for elder abuse legislation than mandatory reporting and the involuntary interventions that characterize child abuse laws.

Other criticisms have been leveled against mandatory reporting. A practical problem is that many States which mandate reporting do not provide services for victims of substantiated reports. Mandatory reporting may discourage abused elderly persons from seeking medical care since these laws require physicians to break the doctor/patient privilege in order to report. Mandatory reporting laws are also said to reinforce ageism: people may feel that if the elderly require special laws for protection they must be weak, vulnerable, and incapable of caring for themselves.

A problem linked to the current mechanism of reporting laws, in general, is that the quality and consistency of data collected through reporting varies between States.[37] The numbers which result are not readily comparable from State to State, and significant inaccuracies may result when attempts are made to aggregate data at the national level. This makes it impossible to draw a clear picture of the national prevalence of elder abuse. In response to this problem, the National Aging Resource Center on Elder Abuse (NARCEA) had developed guidelines for States to follow in gather-

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[35] Fredriksen, K., "Adult Protective Services: Changes with the Introduction of Mandatory Reporting," *Journal of Elder Abuse and Neglect*, Vol. 1, No. 2 (1989), pp. 59-69.

[36] The relevance of child abuse and child protective services to elder abuse and adult protective services is discussed in the following materials: Schene, P. and Ward, S., "The Relevance of the Child Protection Experience," *Public Welfare*, Vol. 46, No. 2 (1988), pp. 14-21; Korbin, J., Anetzberger, G. and Eckert, J., "Elder Abuse and Child Abuse: A Consideration of Similarities and Differences in Intergenerational Family Violence," *Journal of Elder Abuse and Neglect*, Vol. 1, No. 4 (1989), p. 1; "Mandating the Reporting of Elder Abuse," pp. 74-82; "Elder Abuse," pp. 704-710, 716-720.

[37] NARCEA encountered the following difficulties in its effort to compile summaries of elder abuse statistics collected from State APS and aging agencies: (1) "[M]any states provided *all* reports of elder maltreatment received, while other states provided counts that *excluded* those reports which were 'screened out' at intake; (2) while a number of States excluded reports of institutional abuse from their counts of domestic elder abuse, some States were unable to separate reports of institutional abuse from those of domestic abuse; and (3) a large number of states used 'age 60' as the cut-off for counting elder abuse reports, but some states used 'age 65' as the cut-off or were unable to disaggregate 'counts of elder abuse' from 'counts of adult abuse.' " *Summaries of National Elder Abuse Data*, p. 6.

ing and reporting domestic elder abuse statistics.[38] NARCEA believes that the use of these guidelines will result in greater comparability among State-level data, and enhance the credibility of aggregate statistics at the national level.[39] Four States—New York, Ohio, Oregon, and Tennessee—have begun to use some of NARCEA's data gathering suggestions, and there are many other States which collect even more detailed data than NARCEA recommends.

3. Supportive Services

Through their APS programs, many States provide elder abuse victims with a coordinated, interdisciplinary system of social and health services. The services are designed to enable an elderly individual or other vulnerable adult to continue living independently at home and to protect him from abuse. When an individual refuses services deemed necessary for his safety and well-being, the APS agency may attempt to impose them involuntarily.

APS programs assist clients by providing a range of services tailored to individual needs:

> These services are usually classified as preventive, supportive, or surrogate (meaning use of a substitute or guardian). They include medical evaluation, financial management and assistance, psychiatric evaluation and consultation, legal consultation and services, homemaker or household aide, nursing and other health aide in the home, social services (transportation, friendly visiting, shopping, escorts, and others), protective placement, and judiciary and guardianship services.[40]

Specialists from different fields may be involved in providing services, but primary responsibility for the client's well-being rests with a social worker, who must locate resources, see that services are rendered in a systematic and timely manner, and cultivate the support of many different agencies.

Supportive services provided by APS programs raise the following research and policy issues:

(1) *Are APS programs meeting abuse victims' service needs?* Little is known about whether the service needs of elderly abuse victims are effectively met by existing APS programs and whether APS workers are making appropriate placements. A number of interesting findings emerged from a recent study of this issue, which used data collected by the Illinois Department of Aging.[41] The study found that APS workers provided victims of elder abuse and neglect with many of the same types of services that are available to the frail elderly whether or not they suffer from abuse or neglect.[42] Socialization serv-

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[38] National Aging Resource Center on Elder Abuse, *Suggested State Guidelines for Gathering and Reporting Domestic Elder Abuse Statistics for Compiling National Data* (Washington, D.C.: 1990).

[39] Id., p. 1.

[40] *Protective Services for the Elderly: A Working Paper*, p. 20.

[41] Sengstock, M., Hwalek, M., Petrone, S., "Services for Aged Abuse Victims: Service Types and Related Factors," *Journal of Elder Abuse and Neglect*, Vol. 1, No. 4 (1989), pp. 37–56.

[42] *Id.*, p. 52. These included various types of in-home assistance (such as home health aides, housekeeping assistance, and home-delivered meals), counseling, and supervision/reassurance services, as well as institutionalization, housing relocation, and the appointment of or change in a guardian.

ices (such as sending an individual to a senior center or providing home visitation) were infrequently used with abuse and neglect victims. This may be significant given the belief that such services can be beneficial to individuals in socially isolated families with a pattern of violence. Crisis intervention and legal interventions, such as police visits and protection orders, were rarely used, possibly because the APS workers were not accustomed to using them or because services of this kind were unavailable or ineffective in some communities. Self-neglect victims received more types of services per case than victims of other types of abuse and neglect.

Authors of the study could only speculate about reasons for the use or nonuse of various services: Were APS workers unaware of their existence? Did they know that these services would be inadequate? Were some services unavailable in some locations? Are APS workers better equipped to provide services in situations more commonly known to them, such as self-neglect? Did victims of physical abuse receive fewer services than other kinds of victims because APS workers were somehow threatened by the perpetrators or because such behavior was unfamiliar to them?

Additional research of this kind would be useful because it could provide the data necessary to analyze existing service patterns. Such information would enable providers to evaluate the effectiveness of their work with abused elderly persons and to assess shortcomings of available services. The information would also be useful for those who train APS workers and for service providers who wish to develop improved services.

(2) *Are APS programs receiving sufficient funds to carry out their statutory mandate?* APS programs receive their funding from a variety of sources. The major Federal source for APS funding is the Title XX Social Services Block Grant (SSBG) program.[43] Under the SSBG program, the States, the District of Columbia, and the eligible territories receive formula grants for funding a variety of social service programs best suited to the needs of individuals and families residing within the State. Adult protective services is one of the many eligible kinds of programs.[44]

Acting within their discretion to apply SSBG funds as they see fit, in recent years fewer and fewer States have used SSBG funds to support adult protective services: 46 States in fiscal year 1986, 40 States in fiscal year 1987, 34 States in fiscal year 1988, and 30 States in fiscal year 1989.[45] The States that continue to use SSBG dollars to fund APS programs are working

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[43] 42 USC 1397-1397e. In fiscal year 1986, SSBG funds accounted for an estimated 47% of total direct expenditures of APS agencies. State funds accounted for 39%, county funds 13%, and other funding sources 1% of such expenditures. *Adult Protective Services: Programs in State Social Service Agencies and State Units on Aging* (percentages were computed using data on p. 59).

[44] 42 USC 1397a(a)(2)(A).

[45] House of Representatives Committee on Ways and Means, *1990 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, WMCP 101-29, 101st Cong., 2nd Sess. (1990), p. 749. This information is based on the States' preexpenditure reports.

with static or diminished funding levels.[46] Some of the shortfall has been covered by State funds, but States still face the difficult choice of using limited resources to fund child protective services (CPS) or adult protective services programs. CPS programs have fared comparatively well: the average State allocated $53.3 million or 92 percent of protective services funds for CPS in 1989, while it allocated only $2.3 million or 4 percent of its protective services budget for the elderly.[47]

APS programs have lost much of their Federal support as States with a shrinking pool of SSBG dollars have been forced to set priorities for many different social service constituencies. Given this situation, it might benefit victims of elder abuse and neglect if Title XX of the Social Security Act required the States to use a percentage of SSBG funds for their APS programs.

(3) *Do available services adequately take into account the abusers' service needs?* While the immediate concern in abuse and neglect cases is for the victim, services for the abuser may be appropriate in many instances. Where, for example, caregiver stress contributes to abuse of an elder, respite care or training in caregiving techniques may help to alleviate the problem. Job counseling may be an effective tool for the abuser who is financially dependent on his victim. In cases of deliberate abuse or neglect, psychological counseling may be necessary to help the perpetrator change his or her behavior patterns. Since services for abusers can play a role in service plans for abuse victims, it is important to understand the potential benefits of abuser-oriented services.[48]

(4) *What is the level of interagency cooperation between APS agencies and other State and local agencies with a role in elder abuse protection/prevention activities?* Elder abuse prevention and protection activities cut across many State level agencies, including APS agencies, State units on aging, long-term care ombudsman programs, licensing agencies for health facilities and professionals, mental health agencies, and attorney general offices, to name a few. A 1986 study found that while there is a high level of interagency cooperation in many elder abuse prevention and protection activities, these agencies rarely cooperate in planning and resource allocation decisions, research, joint funding of projects and services, and contracting for services.[49] There is anecdotal evidence that in some jurisdictions these agencies are uncooperative about sharing information.

[46] In fiscal years 1985, 1986, and 1987, the SSBG appropriation was $2.7 billion. The 1988 appropriation was raised slightly to $2.75 billion. Appropriations in 1989 were $2.7 billion. The expenditure ceiling for fiscal year 1990 was raised to $2.8 billion, but final amounts available for 1990 were reduced due to sequestration of funds under the Gramm-Rudman deficit reduction legislation. Senate Special Committee on Aging, *Developments in Aging: 1989, Volume 1,* Rept. 101-249, 101st Cong., 2nd Sess. (1990), p. 248. $2.8 billion was appropriated for fiscal year 1991.

[47] *Elder Abuse: A Decade of Shame and Inaction,* p. 40.

[48] *See, e.g.,* Scogin, F., et al., "Training for Abusive Caregivers: An Unconventional Approach to an Intervention Dilemma," *Journal of Elder Abuse and Neglect,* Vol. 1, No. 4 (1989), pp. 73-86.

[49] National Association of State Units on Aging and the American Public Welfare Association, *A Comprehensive Analysis of State Policy and Practice Related to Elder Abuse: A Focus on Roles and Activities of State-Level Agencies, Interagency Coordination Efforts, Public Education/ Information Campaigns* (Washington, D.C.: 1986), p. 27.

It would be helpful to know more about interagency cooperation between APS agencies and the other State and local offices with jurisdiction over elder abuse activities. Encouraging interagency planning may result in a more comprehensive response to the needs of abuse and neglect victims and minimize the expenditure of scare financial resources in the duplication of agency efforts.

4. Involuntary Interventions

Protective services programs are not limited to those who voluntarily accept the services offered. If an adult does not give an informed consent to receive services, or if an adult is considered impaired and unable to make a decision, an APS agency may take steps to impose services involuntarily.

Many States allow their APS agency to initiate, directly or indirectly, a petition for guardianship or conservatorship. Others have created special court procedures within their APS laws to secure court orders for protective services, for placing the client in an institution, for emergency orders when there is imminent danger to the client's health or safety, and for orders authorizing entry into an uncooperative client's home.

Measures such as these raise difficult ethical and practical concerns:

> What happens to the right of self-determination when an adult protective services (APS) worker is confronted with an elderly client who is judgmentally or emotionally impaired? What is the proper balance between a client's right to engage in self-destructive behavior and a service provider's obligation to prevent harm? How are the rights of the community and the rights of the individual to be balanced when forced services and intervention are considered? [50]

(A) Guardianship Proceedings

Guardianship is a "legally prescribed relationship in which the State gives one person (the guardian) the right and duty to make decisions for, and act on behalf of, another person (the ward)." [51] It is a highly intrusive measure. Depending on the extent of authority granted to the guardian, the ward may lose many if not all civil rights and liberties, including the right to manage finances, enter contracts, sue and be sued, and choose medical treatment.

While the method of imposing a guardianship varies from State to State, the process typically begins when a petition is filed with the appropriate court by an entity or individual concerned with the proposed ward's well-being. In recent years, many States have established procedural safeguards such as notice to the proposed ward, the right to be present and represented by counsel at one's guardianship hearing, and a high evidentiary standard of proof re-

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[50] Hayes, C. and Spring, J., "Professional Judgment and Clients' Rights," *Public Welfare*, Vol. 46, No. 2 (spring 1988), p. 22.

[51] The Center for Social Gerontology, *Guardianship and Alternative Legal Interventions: A Compendium for Training and Practice* (Ann Arbor, MI: 1986) (hereafter *Guardianship and Alternative Legal Interventions*), p. SC–4.

quired to win approval of the guardianship petition.[52] In practice these measures are often disregarded.[53]

Traditionally a two part test has been used to determine whether a proposed ward should be adjudicated incompetent: (1) the individual has some condition affecting mental capacity (e.g., insanity, "old age", disease); and (2) as a result of the condition, the individual is unable to properly care for himself or herself or to manage his or her affairs. Today there is a movement toward definitions of functional capacity. These replace the emphasis on labels (e.g., "advanced age") with "objective standards to evaluate a person's ability to manage personal care or financial affairs on a day-to-day basis." [54]

Seventy percent of all guardians are family members of their wards, and the remaining 30 percent are acquaintances, volunteers, public guardians, or one of the growing number of professional guardianship service providers. [55] In many States, limited guardianships are now permitted if the ward is impaired but does not need full fiduciary administration. This is a positive development, since the limited guardian's appointment intrudes on the ward's liberties to the extent required and no further.

(B) SPECIAL COURT PROCEEDINGS TO AUTHORIZE INVOLUNTARY INTERVENTION

Most States have implemented special court procedures to allow APS agencies to secure orders for protective service, and other interventions, for adults needing services but unwilling or unable to accept them. These proceedings typically fail to incorporate the kinds of procedural safeguards that are often required for guardianship proceedings.[56] In these circumstances, "there is great danger that the hearing may become a public agency's *ex parte* presentation of testimony to a sympathetic court that will routinely issue protective orders exactly as requested by the agency." [57] Recently, however, a few States have incorporated due process protections in their protective services proceedings.[58]

Many States have emergency intervention procedures, which pose a particularly stark conflict between the State's interest in protecting vulnerable citizens and the abused adult's rights. In general, these laws require a finding of incapacity and an emergency posing an immediate threat to the client's safety and health. Such laws rarely require legal representation for the client. Emergency intervention is usually of short duration and is designed to allevi-

[52] The trend has been to require clear and convincing evidence. *Protective Services Practice Manual*, p. 72; *Guardianship and Alternative Legal Interventions*, pp. SC-67, SC-68.

[53] A September 1987 Associated Press series highlighted the procedural deficiencies in guardianship proceedings. Based on a review of 2,200 files nationwide, it was determined that in 44% of the cases legal representation was not provided; in 49% of the cases the proposed ward was not present at the hearing; and in 25% of the cases a hearing was not held.

[54] "Trends in Guardianship Reform," p. 561.

[55] *See* House of Representatives Select Committee on Aging, Subcommittee on Housing and Consumer Interests, *Model Standards to Ensure Quality Guardianship and Representative Payeeship Services*, Comm. Publ. No. 101-729, 101st Cong., 1st Sess. (Washington, D.C., 1989), pp. 12-13; *Guardianship and Alternative Legal Interventions*, pp. SC-68 to SC-70.

[56] *See* "Protecting the Elderly: The New Paternalism," pp. 1117-1127.

[57] *Id.*, p. 1117.

[58] For example, recently enacted legislation in New Mexico and Hawaii seeks to ensure due process protections and to give the vulnerable adult a day in court. *1990 Adult Protective Services Legislation*, pp. 22-23.

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ate any immediately harmful circumstances. For example, a victim may be removed from a home where he or she is being abused.[59]

Once the APS agency has obtained a protective order, it is free to do virtually as it wishes with the client since the court seldom imposes limits on the agency. The agency is not held to the kind of fiduciary obligation as is stipulated for a guardian or conservator, nor is it required to report to the court on the client's status or condition as a guardian is required to do. The agency may not even be required to seek renewal of the protective order. Thus, "[t]he client . . . can become the agency's ward for as long as the agency cares to stay involved, which often will be as long as program funds continue." [60] In contrast, a limited guardianship can be written to respond specifically to areas in which an adult needs surrogate decisionmaking.

While guardianship and court proceedings to secure orders for protective services are aimed at sheltering the vulnerable adult from abuse and neglect, the consequences can range from an abrupt disruption of personal life (if removed from the home) to the loss of rights and decisionmaking powers. The vulnerable adult would also suffer from the stigma of having been found incompetent or incapacitated. Furthermore, some of the "solutions" to the client's problems, and institutionalization in particular, may be as harmful as the problem requiring that the elder be protected.

It would be beneficial if advocates, APS workers, and judges would seek to use less restrictive measures—money management devices and durable powers of attorney, for example—which provide protection while enabling a vulnerable elder to retain control over his or her life.[61] It is also important that advocates and others who work with at-risk elders be knowledgeable about (1) the consequences of surrogate decisionmaking measures, and (2) the availability and appropriate use of less restrictive alternatives.[62]

Members of Congress have sponsored legislation that would require States to incorporate procedural safeguards into their guardianship proceedings.[63] These would include, among other things, adequate notice of an impending guardianship hearing, court-appointed counsel for a proposed ward who is unable to obtain representation by other means, evaluation by an independent, professional guardianship evaluation team, and the right to a jury in a guardianship proceeding. The States would also be required to ensure that guardians are trained and are accountable to the courts. The measures proposed by these bills are worthy of serious consideration.

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[59] This approach may violate the U.S. Constitution: "Depriving clients of their physical liberty, their right to make personal care decisions, and their right to control their property for extended periods without an adversary hearing may violate the due process clause of the fourteenth amendment." "Protecting the Elderly: The New Paternalism," p. 1121.

[60] *Id.*, p. 1120.

[61] Such measures are discussed in Parts V-B and V-C of this report.

[62] In an important effort to meet this need, the American Bar Association's (ABA) Commissions on Legal Problems of the Elderly and on the Mentally Disabled have been developing (pursuant to an Administration on Aging grant) a national, multidisciplinary training module on alternatives to guardianship for professionals working with older persons and persons with disabilities. The project is described in the fall 1990 issue of *Bifocal*, a publication of the ABA's Commission on Legal Problems of the Elderly.

[63] In the 101st Congress, relevant legislation included H.R. 1702, H.R. 372, and S. 235.

B. PROTECTING ABUSE VICTIMS IN INSTITUTIONAL SETTINGS

A number of Federal programs and laws exist specifically to protect institutionalized elders from abuse and neglect. These include the OAA long-term care ombudsman program; Federal nursing home law, including the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987, as amended in 1988-90; and Medicare and Medicaid fraud and abuse laws.

1. THE LONG-TERM CARE OMBUDSMAN PROGRAM

Title III of the OAA authorizes formula grants to the States for development of a comprehensive, coordinated service system for older persons. Services are intended to help maintain and support older persons in their homes and communities and to avoid institutionalization whenever possible. Title III funds support a variety of social services programs including congregate and home-delivered meals, multipurpose senior centers, and in-home services for the frail elderly. Funds are given to State units on aging (SUA) which then award funds to the 670 area agencies on aging (AAA). Area agencies are mandated to use the money to coordinate and fund supportive services and to target them to older persons in greatest social and economic need, with particular emphasis on low-income minorities.[64] State units on aging, area agencies on aging, and the local services they fund are referred to collectively as the "aging network."

Pursuant to the OAA, States are mandated to establish and operate long-term care ombudsman programs. These programs, established by Section 307(a)(12) of the OAA,[65] respond specifically to the needs of institutionalized individuals by:

(1) Investigating and resolving complaints made by or on behalf of residents of long-term care facilities;

(2) Establishing procedures for ombudsman access to facilities' and patients' records;

(3) Creating a statewide reporting system to collect and analyze data relating to complaints;

(4) Mandating procedures to assure client confidentiality; and

(5) Providing information to public agencies regarding the problems of long-term care facilities' residents.

Other ombudsmen responsibilities include educating the public training staff and volunteers, and promoting the development of resident and community councils in long-term care facilities. Long-term care ombudsmen do not merely respond to complaints about the quality of nursing home care. They also deal with problems regarding public entitlements, guardianships, or any number of issues that a nursing home resident may encounter. In most jurisdictions, the ombudsman program operates under the direct auspices of the State agency on aging. Where this is not the case, the program is located in an independent State agency, a nonprofit or citi-

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[64] 42 USC 3025(a)(2)(E).
[65] 42 USC 3027(a)(12).

zens' group, a State human services agency, or the Governor's office.[66]

A primary objective of the program is for ombudsmen to establish a regular presence in long-term care facilities to become well-acquainted with residents, employees, and the workings of each facility. Gaining the trust of nursing home residents is critical because half of these individuals are without family and have only the ombudsmen to speak on their behalf.

The 1987 amendments to the Older Americans Act contained a number of provisions which strengthened and improved the long-term care ombudsman program.[67] These include requirements that the States provide ombudsmen with immunity for good faith performance of duties and, if necessary, with adequate legal counsel and representation. State law must protect against the willful interference with the ombudsmen in the conduct of his or her official duties, and against retaliation or reprisal directed toward facility residents and others who complain to or cooperate with ombudsmen. The law established for the first time a separate authorization of funds for the ombudsman program and modified States' minimum expenditure requirements.[68]

There are nearly 600 local ombudsman programs throughout the Nation with approximately 10,000 paid and volunteer staff. According to the Administration on Aging (AoA), the number of complaints handled by ombudsman programs across the country more than tripled from 1982 to 1990, rising from 41,000 in 1982 to nearly 155,000 in 1990.[69] Of the 129,000 complaints received in 1988, AoA reports that approximately 65 percent were fully or partially resolved.[70] Complaints concerning resident abuse and neglect are not separately classified, but AoA reports that ten percent of all complaints received by ombudsmen in 1988 were in the "resident rights" category, which includes, among other things, patient abuse matters.[71]

Despite the ombudsman program's growth and effectiveness, increased funding is critical for the program to carry out existing duties and to expand into new settings where it may play an important advocacy role. In 1981, the OAA was amended to extend the mandate of the long-term care ombudsman program to board and care facilities.[72] Since additional funds were not authorized for

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[66] National Association of State Units on Aging, *Comprehensive Analysis of State Long-Term Care Ombudsman Offices* (Washington, D.C.: 1988), pp. 7–8.

[67] P.L. 100-175. *See* Senate Special Committee on Aging, *Older Americans Act Amendments of 1987: A Summary of Provisions, Public Law 100–175, An Information Paper*, S. Prt. 100-68, Serial No. 100–C, 100th Cong., 1st Sess. (1987) for a discussion of this legislation.

[68] Historically, the long-term care ombudsman program has received OAA Title III–B supportive services funding. Pursuant to Public Law 100–175, Congress authorized $20 million in Title III funding in fiscal year 1988 and such sums as may be necessary for 1989-91 *specifically* for the ombudsman program. Out of this separate authorization, Congress appropriated $988,000 for the program in 1989 and $974,000 for 1990. *Developments in Aging: 1989, Volume 1*, p. 265. Approximately $2.5 million was appropriated for 1991. When all State and Federal funding for the program is added together, the program received $23.3 million in 1988. Administration on Aging, *Report to Congress on Long-Term Care Ombudsman Activities under Title III of the Older Americans Act, National Summary of Statistical Data and Program Activities, Fiscal Year 1988* (hereafter AoA Report for Fiscal Year 1988), p. 5.

[69] *AoA Report for Fiscal Year 1990*, p. 8.

[70] *AoA Report for Fiscal Year 1988*, p. 8.

[71] *Id.* pp. 10–11. This figure is based on data from the 44 jurisdictions which use the AoA's recommended complaint classification scheme.

[72] P.L. 97-115.

these responsibilities, the ombudsman program has been unable to exercise more than minimal oversight in board and care facilities.[73]

Some jurisdictions have made exciting progress in expanding the ombudsman program into areas other than long-term care facilities, such as hospitals and home and community-based care settings. The Minnesota Acute Care Ombudsman Section serves the needs of elderly hospital patients. In 1989, this program handled 331 complaints, of which 30, or 10 percent, were categorized as "residents' rights".[74] A number of ombudsman programs have also expanded into the home health care area.[75] The Ohio legislature allotted $540,000 for this purpose for each fiscal year from 1989 through 1991, and it was expected that the program would serve 1,000 clients in its first year of operation and 2,000 in its second year.[76] Unfortunately, Ohio's lack of a licensure law for home health agencies has hampered progress in resolving complaints and in gathering data on providers.

The ombudsman confidentiality requirements under the OAA are another aspect of the program which could be improved.[77] These provisions, which protect the confidentiality of an ombudsman's communications with a long-term care facility resident, directly conflict with some States' mandatory reporting laws, which require that certain individuals report known or suspected cases of abuse. If a State's reporting law covers ombudsman,[78] it poses a difficult practical and ethical dilemma: whether to betray a resident's confidence and Federal law to obey the State reporting law, or whether to disregard State law and risk the attendant civil or criminal penalty. One way to correct this situation would be to amend the OAA to give ombudsmen the right to abstain from the reporting of abuse where to report would jeopardize a victim's wellbeing.

2. Federal Nursing Home Law

For many years the Federal Government has regulated nursing homes by setting standards for facilities that participate in the Medicaid and Medicare programs.[79] Until recently, qualifying fa-

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[73] A recent study noted three major obstacles to the program's success in board and care homes: (1) lack of resources, particularly at the substate level, and the subsequent prioritizing of nursing home issues; (2) ineffective regulation of licensed board and care homes and poor enforcement; and (3) the high number of licensed and unlicensed board and care homes. *A Study of the Involvement of State Long Term Care Ombudsman Programs in Board and Care Issues,* p. 48.

[74] Office of Ombudsman for Older Minnesotans, *1989 Annual Report.*

[75] The States that have expanded their ombudsman programs into the home health care area are Alaska, Colorado, Idaho, Maine, Minnesota, Ohio, Pennsylvania, Virginia, Wisconsin, and Wyoming.

[76] Tewksbury, L., "Home Care Ombudsman Program: Helping to Ensure Quality Home Care Services," *Ohio's Heritage,* Aug. 1989, pp. 4-5.

[77] "The State agency will establish procedures to assure that any files maintained by the ombudsman program shall be disclosed only at the discretion of the ombudsman having authority over the disposition of such files, except that the identity of any complainant or resident of a long-term care facility shall not be disclosed by such ombudsman unless—(i) such complainant or resident, or the individual's legal representative, consents in writing to such disclosure; or (ii) such disclosure is required by court order." 42 USC 3027(a)(12)(D).

[78] For example, an ombudsman might be required to report abuse if State law required reporting by anyone with knowledge or reasonable cause to believe that an abuse incident has occurred.

[79] Strauss, P., Wolf, R., and Shilling, D., *Aging and the Law* (Chicago, IL: Commerce Clearinghouse, Inc., 1990), pp. 490-492, provides a concise overview of pre-OBRA conditions of participation.

cilities were divided into two groups, skilled nursing facilities (SNF) and intermediate care facilities (ICF). SNFs and ICFs were subject to conditions of participation that addressed operational and physical plant requirements. Prior law dealt with patient abuse merely by requiring that facilities maintain accounting systems for residents' personal funds, and by forbidding the commingling of patient funds with funds of the facility or its employees.[80]

To monitor nursing homes' compliance with Federal standards, the Federal Government has traditionally contracted with State governments to conduct annual inspections, called "surveys," of the quality of care and compliance with Federal law in each Medicare and Medicaid-certified facility. The Federal Government itself inspects some nursing homes on a "spot-check" basis to monitor the quality of State inspections and to look into reports of problems. The Health Care Financing Administration (HCFA) is the Federal agency responsible for conducting survey activities.

The nursing home survey process requires State surveyors to visit nursing homes, inspect them, and make reports on official forms. Inspections focus on how the nursing home staff meets residents' individual needs and how the physical surroundings support residents' well-being.[81] HCFA requires State and Federal surveyors to focus on evaluating resident care outcomes and to deemphasize review of a facility's policies and procedures.[82] Under prior law, noncompliance with the Federal requirements was punishable by the extreme sanction of closing a facility and relocating its residents.

(A) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

The Nursing Home Reform Amendments contained in the Omnibus Budget Reconciliation Act of 1987 (OBRA), as amended in 1988–90, is the most comprehensive nursing home law passed by Congress since the enactment of Medicare and Medicaid.[83] OBRA covers all aspects of nursing home law: (1) requirements that facilities must meet in order to participate in Medicare and Medicaid; (2) survey and certification procedures; and (3) enforcement, including intermediate sanctions. OBRA's extensive requirements for the Federal and State governments and nursing facilities were implemented over a 2½-year period, culminating with the implementation of requirements for nursing homes on October 1, 1990.

Residents' rights. OBRA elevated the importance of residents' rights and included a number of provisions which should have a direct impact on resident abuse and neglect. The law requires that nursing facilities "promote and protect the rights of each resident. . . ."[84] The specifically enumerated rights include:

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[80] *Id.*, p. 492.

[81] A three-part review is required: a check of compliance with (1) the Life Safety Code of the National Fire Protection Association, (2) administrative and structural requirements, and (3) direct resident care requirements. 42 CFR 488.110(a). Surveyors are required to observe individual residents to determine whether they are, among other things, well-groomed, properly fed, living in clean surroundings, and are able to exercise their rights. 42 CFR 488.110(e)(3).

[82] *See Law and Aging, supra n. 76,* pp. 499–500, for a discussion of the litigation that brought about this focus on the outcome of nursing home care.

[83] P.L. 100–203, Title IV, Subtitle C. The law is codified at 42 USC 1395i–3 (Medicare) and 42 USC 1396r (Medicaid). *Nursing Home Reform Law: The Basics*, by the National Citizens Coalition for Nursing Home Reform (1990), provides an excellent overview of this law.

[84] 42 USC 1395i–3(c); 42 USC 1396r(c).

1. The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical and chemical restraints imposed for discipline or convenience.[85] The regulations implementing OBRA add a prohibition against verbal and sexual abuse. Facilities must (1) develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of residents, and (2) refrain from hiring individuals convicted of abusing, neglecting or mistreating individuals.

Any alleged mistreatment, neglect, or abuse, including "injuries of unknown source," must be reported immediately to the administrator of the facility or to other officials in accordance with State law and must be fully investigated. Facilities must take steps to guarantee that further abuse is prevented while the investigation is in progress. If an alleged violation is verified, appropriate corrective action must be taken.

2. The right to protection of personal funds. If a resident chooses to have the nursing home manage his or her funds, the home must manage those funds in a manner designed to protect the resident from financial abuse.[86] Facilities must:

- keep funds over $50 in an interest-bearing account separate from the facility account;
- keep funds that do not exceed $50 in a separate account or petty cash fund;
- keep a complete, separate accounting of each resident's funds and a written record of all transactions available for review by residents and their representatives;
- not charge residents for items or services covered by Medicaid;
- notify Medicaid recipients when their balance comes within $200 of the Medicaid eligibility limit and how this would affect their eligibility;
- upon a resident's death, turn over funds and a final accounting to the individual administering the resident's estate; and
- purchase a surety bond to secure residents' funds in the facility's keeping.

To monitor facilities' compliance with OBRA's residents' rights requirements, HCFA has directed nursing home surveyors to interview individual residents and resident councils about the facility's compliance with these requirements. Inspectors must attempt to determine the extent to which residents feel satisfied with their ability to exercise their rights. They must also interview family members of residents who are unable to be interviewed due to mental or physical impairment.

Nurse's aides training and competency. Over 70 percent of the nursing personnel in long-term care facilities are nurse aides, and they deliver as much as 90 percent of hands-on resident care.[87] It is

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[85] The regulations implementing these provisions of the law may be found at 42 CFR 483.13.
[86] 42 CFR 483.10(c).
[87] *Developments in Aging, Vol. 1,* p. 259.

widely believed that competent, trained nurse aides are a prerequisite for quality nursing home care.

In response to the need for qualified nurse aides, OBRA established new requirements for nurse aide training.[88] Under the law and HCFA's regulations, newly hired nurse aides must complete a 75-hour State-approved training course that includes instruction in basic nursing skills, personal care skills, cognitive, behavioral, and social care, and residents' rights. The law allows for exemptions, under certain conditions, for aides who have previously received training and for aides who have worked for the same employer for 24 consecutive months. Nurse aides must be evaluated and certified as competent through a State competency evaluation program. Facilities are required to provide regular performance reviews and inservice education.

Information about a nurse aide's training and competency evaluations will be kept on a State-controlled registry.[89] The registries will also contain any official findings that an aide has abused or neglected a resident or misappropriated a resident's property. Before hiring a nurse aide, a facility must contact the State registry for information concerning that individual.

Enforcement. OBRA requires States and the Federal Government to implement enforcement systems with sanctions of varying levels of severity geared to the nature of a facility's problems.[90] Having a variety of sanctions available to respond to problems is an important improvement over prior law, which sometimes required that facilities be closed for noncompliance with Federal standards. This sanction put residents at great risk because it forced them to leave their home, and it was rarely imposed because of its drastic nature.

Under OBRA, if a State or the Federal Government finds a facility out of compliance and the deficiencies do not immediately jeopardize the health or safety of its residents, the State or the Department of HHS may cancel the facility's Medicare/Medicaid contract, prevent the home from accepting new Medicare/Medicaid admissions, impose fines, or appoint temporary management to correct the problem.

If a facility's deficiencies immediately jeopardize residents' health or safety, the State or the Department of HHS must take immediate action to remove the deficiencies and can either cancel the Medicare/Medicaid contract or appoint temporary management.

Nursing staff requirements. OBRA requires all nursing facilities participating in Medicare and Medicaid to have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty 24 hours per day, 7 days per week.[91] These requirements may alleviate the problems of resident abuse and neglect by nurse aides by ensuring their supervision by a professional nurse.

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[88] 42 USC 1395i-3(b)(5); 42 USC 1396r(b)(5). Prior to OBRA, there were no Federal requirements concerning training and competency evaluation of nurse aides. Conditions for Medicare and Medicaid merely required that all staff be suitably and appropriately trained. 55 F.R. 10938, 10939 (Mar. 23, 1990) (preamble to HCFA's nurse aide training regulations).

[89] 42 USC 1395i-3(e)(2); 42 USC 1396r(e)(2).

[90] 42 USC 1395i-3(h); 42 USC 1396r(h).

[91] 42 USC 1395i-3(b)(4)(C); 42 USC 1396r(b)(4)(C).

In spite of this important statutory safeguard against resident abuse and neglect, legislators responded to industry concerns about nurse shortages and cost constraints by permitting a waiver of nurse staffing requirements under certain circumstances. To mitigate the possible adverse effects of such waivers, OBRA 1990 included requirements that: (a) any State agency granting a waiver must so notify the State long-term care ombudsman and the protection and advocacy system in the State for the mentally ill and the mentally retarded; and (2) any nursing facility that is granted such a waiver must so notify facility residents (or where appropriate, their guardians or legal representatives), and members of their immediate families.[92] Despite these safeguards, if waivers are widely sought and granted then the beneficial effect of OBRA's nurse staffing requirements could be severely undermined.

Survey and certification process. OBRA 1987 made significant changes in the nursing home survey and certification process.[93] Under the law, each facility is subject to an unannounced "standard survey" at least once a year, but no less than every 15 months. Facilities found to be delivering substandard care are subject to an extended survey as well as State sanctions. States must maintain procedures and staff adequate to investigate complaints of resident abuse, neglect, or misappropriation of residents' property, and after notice and opportunity for a hearing must report a guilty individual to the appropriate State licensure board or registry. The State must have adequate staff to investigate other kinds of complaints and to monitor on site, on a regular basis, the compliance of facilities found in violation or suspected of violations.

The survey and certification process is a potentially powerful tool for preventing resident abuse and neglect. However, an April 1990 report by the Office of the Inspector General (OIG) of HHS suggested that the process is not meeting its potential.[94] Those who responded to an OIG survey noted the following inadequacies in the survey process:

(1) Survey deficiencies are facility-oriented, and abuse is more often an individual issue rather than a facility-wide problem.

(2) Since resident interviews are of short duration, surveyors may lack the time necessary to gain the resident's confidence and overcome his or her fear of reporting abuse.

(3) The survey process leaves little time for extensive investigation of problems.

(4) Surveyors are not trained investigators.

(5) There is considerable variation among States and Federal regions in the intensity, focus, and quality of resources devoted to the conducting of surveys.

(6) Survey guidelines are subject to varying interpretations by the individual surveyors. What one cites as a deficiency, another may not report due to "extenuating circumstances."

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[92] P.L. 101-508.

[93] 42 USC 1395i-3(g); 42 USC 1396r(g).

[94] Office of the Inspector General/Office of Evaluation and Inspections, *Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints (Apr. 1990)*, pp. 21-22.

(7) Nearly half (47%) of the OIG survey respondents said that surveyors often perform little or no analysis of complaints made prior to the survey, usually because they lack easy access to nursing home complaint files or to statistics specific to the nursing home being surveyed.

Under OBRA's survey requirements, it is possible that some of these problems will be alleviated. For example, OBRA requires that surveys be conducted by a trained multi-disciplinary team, which should mitigate the problem of inadequately trained surveyors. The new process will include indepth private interviews with a sample of residents, a private discussion with the resident council, and interviews with families of residents who are unable to be interviewed. These interviews should allow the survey team to acquire insight into a facility's problems and give residents the confidence to report abuse and neglect.

In light of these many provisions, OBRA 1987 is clearly the most important piece of Federal legislation enacted with respect to protecting nursing home residents from abuse and neglect. Oversight must be exercised to ensure that the law is implemented in the manner intended and that exceptions or waivers allowed by regulation do not invalidate overdue reforms.

3. Medicare and Medicaid Fraud and Abuse Laws

Medicaid Fraud Control Units (MFCU) are law enforcement units authorized by Federal law to investigate and prosecute cases of patient abuse and neglect in residential health care facilities that receive Medicaid funds.[95] An MFCU is comprised of lawyers, auditors and investigators who are managed by a Unit Director. The Unit Director is typically an Assistant Attorney General operating under the office of the Attorney General, which has statewide authority to conduct criminal prosecutions.

The legislative preference is for the MFCU to investigate and prosecute its own cases on a statewide basis, but Federal law recognizes that this is not possible in every State. Currently, 10 of the 39 States with MFCUs do not prosecute their own cases but refer them to other prosecutors. Thirty-one MFCUs are located within the office of the State Attorney General and the remaining eight are located in other State agencies with law enforcement or auditing responsibilities. To encourage States to establish MFCUs, the Federal Government reimburses 90 percent of the States' costs of operating an MFCU for the first 3 years and reimburses 75 percent of the costs thereafter.

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[95] 42 USC 1396b(q)(4). MFCUs also investigate and prosecute cases of Medicaid provider fraud and violations of State laws pertaining to fraud in the administration of the Medicaid program. 42 USC 1396b(q)(3).

When Medicaid was established by Congress in 1965 as a medical assistance program for low-income people, its enabling legislation contained no specific provision for investigative or prosecutorial functions, and neither the Federal nor the State governments policed the program. By the mid-1970's, Congress became aware of widespread fraud and abuse in the Medicaid program. Following a series of hearings, Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, which established the MFCUs.

The monthly *Medicaid Fraud Report*, published by the National Association of Attorneys General, is a valuable resource for the advocate who desires to be informed about the work of the MFCUs. An overview of the MFCU program may be found in: Ross, L.M., ed., *State Attorneys General: Powers and Responsibilities* (Washington, D.C.: Bureau of National Affairs, Inc., 1990), Chapter 26, "Medicaid Fraud."

The Medicare and Medicaid Patient and Program Protection Act of 1987 [96] provides additional protection to abuse and neglect victims by requiring the Secretary of HHS to exclude from participation in a number of government health programs (including Medicaid, Medicare and the Social Services Block Grant programs) individuals or entities convicted of program-related patient abuse or neglect. [97] Exclusions for patient abuse or neglect are mandatory, must last for at least 5 years, and cannot be waived. The law gives the Secretary discretionary authority to exclude entities or individuals who have been convicted of program-related fraud, theft, embezzlement, breach of fiduciary duty, or financial abuse.

Believing that their work would be facilitated by certain changes in State law, the National Association of Attorneys General and the National Association of Medicaid Fraud Control Units have issued guidelines for State legislation to prohibit patient and resident abuse. The preamble to the guidelines states that:

> Prosecutions have been significantly hampered by the lack of specific State statutes addressing the unique aspects of patient abuse crimes, defining the duty of health care facilities to protect their sick and elderly residents from harm and neglect, resolving the evidentiary problems specific to patient abuse crimes, and coordinating the responsibilities of the various agencies within State government overseeing institutional care. [99]

These guidelines have been given serious consideration by legislatures in a number of States. The guidelines, among other things, (1) define the term "abuse" to include the inappropriate use of physical or chemical restraints, medication, or isolation; (2) recommend reporting requirements designed to enhance the quality of cases that are referred to MFCUs and avoid a flood of reports that would deflect resources away from the most serious cases; (3) advocate a specific grant of jurisdiction to State Attorneys General for a civil cause of action or a regulatory action in the quality of care area; and (4) define the term "care facility" to include the widest range of facilities in which persons dependent on others for their health or resident care needs might be found.

The proposed definition of "care facility" is highly significant given the anticipated expansion of Medicaid-reimbursed home and community-based care. The States are expected to increase their use of Medicaid waivers which authorize reimbursement of long-term care provided in home and community-based settings. Spurred by OBRA 1990, some States are also expected to offer home and community-based care as an optional service under Medicaid. [99] To better protect individuals receiving these expanded

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[96] P.L. 100-93, codified at 42 USC 1320a-7.

[97] For example, in *Summit Health Ltd., dba Marina Convalescent Hospital* v. *The Inspector General* (HHS Departmental Appeals Board, Appellate Div.; June 29, 1990), a long-term care facility was excluded from participating in the Medicare program for failing to give prescribed medicine and treatments to its residents. The Appeals Board stated, "Obviously, patients in long-term care facilities who fail to receive medications and treatments as prescribed and whose care is not properly planned are being 'neglected' and may suffer serious health consequences as a result." *CCH Medicare and Medicaid Guide,* Para. 38,653.

[98] National Association of Attorneys General and National Association of Medicaid Fraud Control Units, *Guidelines and Commentary for Legislation to Prohibit Patient and Resident Abuse* (Sept. 1988), p. 2.

[99] These programs are discussed in Section V-A of this report.

forms of Medicaid-reimbursed care, the legislation and regulations defining the scope of the MFCUs' authority should be revised. Protection is currently limited by Federal law, which specifies that MFCUs may review, and, where appropriate, act upon complaints of abuse and neglect of patients "in health care facilities" receiving payments under the State Medicaid plan.[100]

MFCUs sometimes face systemic problems in carrying out their Federal mandate to prosecute cases of patient abuse and neglect. For example, California's MFCU, the Bureau of Medi-Cal Fraud and Patient Abuse, has encountered underreporting in fiduciary abuse cases, in part due to the State Department of Health Services' inability to thoroughly audit patient trust accounts.[101] The Bureau also believes that its response to the problem of patient neglect has been inadequate given the high level of public concern because police, prosecutors, and the courts take a "cavalier" attitude toward such matters.[102] In contrast, the Bureau has had little difficulty prosecuting cases involving classic assaults or batteries in a long-term care environment. Local police agencies and prosecutors are willing to investigate and prosecute these matters, have little difficulty doing so, and win sentences which are generally slightly more severe than sentences for similar acts committed outside long-term care facilities.

It appears that the MFCU program has experienced a high level of success. However, information on the outcome of patient abuse and neglect prosecutions is not reported separately by the Office of Inspector General of HHS which has oversight responsibility for the MFCUs and which collects data from the MFCUs regarding their investigations and prosecutions.[103] Such information would be valuable for assessing the level of success that MFCUs are experiencing with their prosecutions for patient abuse and neglect, and to determine the extent of abuse and neglect occurring in institutional settings.

C. DOMESTIC VIOLENCE LAWS

All 50 States and the District of Columbia have domestic violence or family abuse laws, which are designed to compel the abuser to leave the home. These laws, which are generally used in cases of spousal abuse, may also be useful in the elder abuse context.[104]

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[100] 42 USC 1396b(q)(4); 42 CFR 1002.311(b).

[101] Adler, S., "California's Experience with Patient Abuse Cases," *Medicaid Fraud Report*, Mar. 1990, pp. 1–4.

[102] *Id.*, p. 4.

[103] *See, e.g.*, Department of HHS, Office of the Inspector General, *Annual Report: State Medicaid Fraud Control Units, Fiscal Year 1988* (issued Dec. 1989), which states that the MFCUs achieved a total of 466 convictions during 1988, but does not indicate how many of these convictions were for patient abuse and neglect.

The Oct. 1986 Government Accounting Office report, *Results of Certified Fraud Control Units* (GAO/HRD-87-12FS), notes that 743 and 954 patient fraud and abuse matters were reviewed by MFCUs in 1984 and 1985 respectively, but does not provide information on the status or disposition of these matters (p. 9).

[104] The use of domestic violence acts in the elder abuse setting is discussed in the following sources: Lupinski, L., "Elder Abuse: A Pressing Need for Federal Assistance," 5 *Public Law Forum* 137, 148–52 (1986); Mathews, D., "The Not-So Golden Years: The Legal Response to Elder Abuse," 15 *Pepperdine Law Review* 653, 659–661 (1988); Quinn, M. and Tomita, S., *Elder Abuse and Neglect*, pp. 222–223, Legal Counsel for the Elderly, *Protective Services Practice Manual*, pp. 89–90. Another helpful resource is "Legal Help for Battered Women" by L. Lerman, which appears in Chapter 3 of Costa, J., *Abuse of Women: Legislation, Reporting, and Prevention* (Lexington, Mass.: Lexington Books, 1983).

Under a domestic violence statute, a judge can issue a protection order, also known as a restraining order, in situations involving attempted or threatened physical harm as well as in cases involving actual physical harm or injury.[105] Depending on State law, the court may order the abuser to do one or more of the following: (1) refrain from abusing a member of the household; (2) refrain from contacting the victim in any way; (3) move away from and stay out of the residence shared with the victim, even if the title or lease is in the abuser's name; (4) provide alternate housing for the victim; (5) obtain counseling; and (6) pay the victim a sum of money for medical expenses, lost wages, moving expenses, property damage, court costs, or attorney's fees.

An abuse victim may obtain a protection order by filing a petition in the court which has the authority to issue it. The court then schedules a hearing, usually within 2 weeks after the petition is filed. A temporary protection order may be issued after the petition has been filed and prior to the hearing. Violation of a protection order is a crime for which the abuser can be arrested, but responsibility for enforcement falls on the victim, who must be willing to call the police whenever the abuser breaks the order.

While laws vary from State to State, many jurisdictions will issue a protection order to anyone abused by a spouse, former spouse, family member, household member, or former household member. Since some States apply these laws only to abused wives or spouses, a protection order is unavailable if the elder is abused by someone other than a spouse. In other States, protection orders cannot be obtained unless a divorce or separation petition has been filed. As a result, even if the abuser is a spouse, a protection order is unobtainable without a divorce or separation proceeding.

Usually only the victim may petition the court for a protection order, and there generally are no provisions in the laws which permit the victim's friends to file on his or her behalf. Since many older persons are intimidated and confused by the process of obtaining a protection order, this avenue of relief is rarely pursued. Loyalty or shame may also prevent abused elders from seeking protection orders against family members.

Assuming that the elder obtains a protection order, the abuser's absence from the home may leave the elder without a caregiver. Without an affordable and accessible network of home and community-based care, the abused elder may then face the terrible choice of staying in the abuser's care or entering an institution. While there are shelters that provide abuse victims with alternative housing, it is only the rare exception that can provide disabled elders with the special services they need, and many shelters are available only to abused spouses. Emergency shelters designed expressly for abused and neglected elders are few and far between. One study

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[105] A protection order is not to be confused with a protective order, which was discussed in connection with involuntary interventions under APS laws.

found that an emergency shelter for abused elders located in Washington, D.C. helped the recovery of its residents by empowering them with a sense of their options and by diminishing their sense of helplessness.[106] Promising efforts such as this are worthy of review and support.

[106] Cabness, J., "The Emergency Shelter: A Model for Building the Self-Esteem of Abused Elders," *Journal of Elder Abuse and Neglect,* Vol. 1, No. 2 (1989), pp. 71-82.

SECTION V. PREVENTION

A. HOME AND COMMUNITY-BASED CARE

Two issues arise when considering the potential of the home and community-based care system to prevent the occurrence of elder abuse:

To the extent that caregiver stress contributes to the incidence of elder abuse, do Federal programs provide adequate home and community-based care benefits and services to alleviate the emotional and financial burdens experienced by family caregivers?

When home and community-based care is available, can existing quality control systems protect care recipients from abuse or neglect by inept or unscrupulous care providers?

1. Access and Affordability

Home and community-based care has the potential to improve the quality of life for a disabled elder while providing much needed respite for an unpaid caregiver who might grow abusive under the strain of providing care. A number of government programs offer benefits and services to elders who wish to remain at home.[107] The most important of these are the Medicare and Medicaid programs. However, Medicare-reimbursed home care is available only to elders needing skilled medical assistance, and Medicaid-funded home care is available on a limited basis to low income seniors. Non-medical home and community-based care is available through the Social Services Block Grant and the Older Americans Act programs, but due to limited resources these programs reach relatively few of the elders who could benefit from their services. One Federal program, the Supplemental Security Income program, actually shifts greater responsibility to unpaid caregivers by reducing benefits paid to an elder cared for in another person's home and receiving in-kind support from that person.

Medicare: Medicare is the Federal health insurance program for the elderly and disabled.[108] The program's primary purpose is to provide insurance for hospitalization and doctor expenses, and eligibility requirements are geared accordingly. To qualify for Medicare reimbursement of home health care costs, an individual must be under a doctor's care and confined to the home.[109] Home health care services, which may include part time or intermittent skilled nursing care or physical, occupational, or speech therapy, must be

[107] *See generally* Feldblum, C., "Home Health Care for the Elderly: Programs, Problems, and Potentials," 22 *Harvard Journal on Legislation* 193 (1985).

[108] 42 USC 1395–1395ccc.

[109] 42 USC 1395x(m); 42 CFR 409.40–46.

provided under a plan drafted and periodically reviewed by a doctor. Also covered are medical social services provided under a doctor's direction; medical supplies and durable medical equipment; part time or intermittent services of a home health aide (to the extent permitted by regulation) and, in the case of a home health agency (HHA) that is affiliated with a hospital, medical services from an intern or resident.

As a result of the restrictions on the types of home care that qualify for Medicare reimbursement, seniors suffering from chronic illnesses or the degenerative processes of aging generally do not qualify for Medicare reimbursement of home health care costs. The Medicare home health benefit expressly excludes certain services that assist elders who are disabled but not medically ill. For example, regulations expressly exclude coverage of "meals-on-wheels," housekeeping services, and transportation to take a homebound elder to a place where she or he can get medical services.[110] Since Medicare covers skilled nursing care and home health services only on a part time or intermittent basis, when Medicare home care is available the number of hours of care is generally less than the amount needed.

Due to these restrictions, Medicare reimbursement of home health care is minuscule compared to the demand. In 1985, an estimated 5.2 million of the total elderly population were mildly to severely disabled with a need for assistance with the activities of daily life.[111] However, the total number of Medicare home care visits in 1986 was only 39 million.[112] At these rates, the elderly person requiring daily care would receive it for only 1 week out of the year.

Medicaid. Medicaid is a combined Federal/State funding source for health care for low-income persons.[113] It is the Federal program, administered by the States, which is a major public insurance underwriter for long-term care, particularly nursing home care.

Prior to 1981, Federal law limited Medicaid home care services to those requiring acute care. In Section 2176 of the Omnibus Budget Reconciliation Act of 1981, Congress shifted course and authorized the Secretary of HHS to expand Medicaid beyond the traditional acute care model. Under "2176 waivers" (named after the section in the act which authorized them) the Secretary of HHS may authorize States to waive certain Medicaid requirements to allow States to finance home and community-based services for Medicaid beneficiaries who, without such services, would require the same level of care in an institution.[114] The cost of services under the waiver must not be greater than the cost of services which would be furnished in an institution absent the waiver. Home and community-based care services that are reimbursable under the waivers include case management, homemaker/home health aide serv-

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[110] 42 CFR 409.41.

[111] Senate Special Committee on Aging and the American Association of Retired Persons, *Aging America: Trends and Projections*, 1987-88 ed., p. 99. This number is expected to reach 7.3 million by the turn of the century, 10.1 million by the year 2020, and 14.4 million by 2050. *Id.*

[112] Government Accounting Office, *Medicare and Medicaid: Updated Effects of Recent Legislation on Program and Beneficiary Costs*, GAO/HRD-88-85 (1988), p. 27.

[113] 42 USC 1396-1396s.

[114] 42 USC 1396n(c).

ices, personal care services, adult day care and respite care. As of 1987, 46 States had established waiver arrangements serving roughly 60,000 elderly and disabled persons,[115] a relatively small number given the need for home and community-based care.

Section 4102 of OBRA 1987 aimed to expand the Medicaid waiver program, and created a new waiver authority under which the States can provide home and community-based services for the elderly alone.[116] It is anticipated that several States will establish more expansive home and community-based care programs under this authority.

The States have generally found that waiver programs allow them to provide less costly home and community-based care, according to a recent Government Accounting Office report.[117] However, eight of the nine States studied by the GAO experienced difficulty with the initial waiver application and review process. The reasons cited were that (1) the application process was long and untimely; (2) the waiver regulations seemed to be constantly changing, which required rewriting applications several times; and (3) HCFA's reviews raised inconsistent issues.

In 1990, Congress passed legislation which gives States the option of providing Medicaid-reimbursed noninstitutional care to low-income, functionally disabled persons over the age of 65.[118] These services may include homemaker/home health aides, nursing and personal care, chore assistance, respite care, training for family members in managing a disabled elder, and adult day care. The law establishes quality standards for the delivery of home and community-based care services. It also requires the States to investigate allegations of abuse, neglect, and misappropriation of property by care providers. While similar to 2176 waivers in the types of services that may be offered, the advantage of this approach is that it eliminates the troublesome process of applying for and administering waivers.

States are also given the option of providing "personal care services" under their Medicaid programs.[119] Personal care services are medically oriented services which meet an individual's physical requirements and allow him or her to be treated by a physician on an outpatient basis. They are intended to prevent inappropriate institutionalization if the patient does not require skilled nursing care. A care provider must be supervised by a registered nurse and may assist clients with personal hygiene, dressing, feeding, or transfer or ambulatory needs.

Social Services Block Grants. In 1975, the various Social Security Act provisions authorizing social services were consolidated into a new Title XX. In 1981, Congress amended Title XX to create the Social Services Block Grant (SSBG) program, which operates as an entitlement program to States with funds allocated on the basis of

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[115] Senate Special Committee on Aging, *Developments in Aging: 1989, Volume 1,* p. 268.

[116] P.L. 100-203, 4102, codified at 42 USC 1396n(d).

[117] Government Accounting Office, *Health Care: Nine States' Experience with Home Care Waivers,* GAO/HRD-89-95 (1989). The nine Sstates studied by the report, California, Florida, Georgia, Maine, Maryland, Minnesota, Mississippi, Ohio, and Texas, administered a total of 32 home and community-based waivers.

[118] OBRA 1990, P.L. 101-508, 4711. The law resulted from bills that Senator Rockefeller and Congressman Wyden introduced in the 101st Congress. S. 1942 and H.R. 3933.

[119] 42 CFR 440.170(f).

population. The program's goals include the prevention of (1) inappropriate institutionalization through home and community-based care for diverse client groups and (2) neglect, abuse, and exploitation of children and adults who are unable to protect themselves.[120] The States are given great latitude to decide what services will be provided and what groups will be served.

Although the SSBG program is the major social services program supported by the Federal Government, its ability to provide home and community-based care is very limited. Since the program provides a variety of social services to a diverse population, it has competing demands and provides only a limited amount of care to the elderly. The extent of home and community-based care for the elderly which is supported by the SSBG program is unknown, because the 1981 legislation that created the program eliminated requirements that States report information about their use of these funds.[121] The Family Support Act of 1988 will remedy this situation by requiring the States to submit annual reports containing detailed information on the services actually funded and the individuals served through Title XX funds.[122] HHS has published a notice of proposed rulemaking to implement these requirements.[123]

Older Americans Act.[124] The Older Americans Act (OAA) carries a broad mandate to improve older persons' lives in the areas of income, emotional and physical well-being, housing, employment, social services, and civic, cultural and recreational opportunities. Title III of the OAA authorizes formula grants to the States for the development of a comprehensive and coordinated service system. Services are intended to (1) secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care; (2) remove individual and social barriers to economic and personal independence; and (3) provide a continuum of care for the vulnerable elderly.[125]

Under Title III, area agencies are mandated to target services to older persons with the greatest social or economic needs, with particular attention to low-come minority individuals.[126] They are also required to spend a portion of their supportive services allotment on in-home services.[127]

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[120] 42 USC 1397(3), (4).

[121] To help fill the information gap, the AARP conducted a survey in 1987 to determine the amount of SSBG funds being used for services to the elderly. The survey showed that 47 States used some portion of their SSBG funds to provide services to older persons. Forty-four of the States submitted estimates on the percentage of services allocated for the elderly. The estimates ranged from less than 1 percent up to 50 percent. The survey also found that while the level of SSBG funding of services to older persons held steady or declined slightly, there was nevertheless a large decline in the number of older persons assisted. This may have been due to stricter eligibility requirements placed on services like in-home care. Gaberlavage, G., *Social Services to Older Persons Under the Social Services Block Grant* (Washington, D.C.: AARP, 1987), pp. 6–8.

[122] P.L. 100–485, 607, codified at 42 USC 1397e.

[123] 55 Fed. Reg. 12678 (Apr. 5, 1990).

[124] 42 USC 3027(a)(12).

[125] 42 USC 3021(a).

[126] 42 USC 3025(a)(2)(E). The OAA defines the term "greatest social need" to mean "the need caused by noneconomic factors which include physical and mental disabilities, language barriers, and cultural, social or geographical isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens such individual's capacity to live independently." 42 USC 3022(21). The term "greatest economic need" is defined as "the need resulting from an income level at or below the poverty levels established by the Office of Management and Budget." 42 USC 3022(20).

[127] 42 USC 3026(a)(2)(B).

While in-home services have been authorized under the OAA for many years, until recently there was no separate authorization for this purpose. In recognition of the growing need for in-home services, the 1987 Older Americans Act Amendments (P.L. 100-175) created a new Part D under Title III, which authorizes funds for non-medical, in-home services for frail older persons. Funding was authorized through 1991 for homemaker and home health aide services; visiting and telephone reassurance; chore maintenance; in-home respite care and adult day care as a respite service; and minor modifications of homes necessary to facilitate the ability of older individuals to remain at home, not to exceed $150 per client.

Under the OAA, home and community-based care is provided without Medicare's restrictions and without Medicaid's income tests. In some cases, OAA funds may be used to assist persons needing home care but whose Medicare and Medicaid benefits have been exhausted or who are ineligible for Medicaid. In 1988, an estimated 8.2 million persons received social services under Title III-B.[128] These included access services such as transportation and information and referral, and a wide range of other social and health services offered in the home and in community settings.

While generally successful in service delivery, area agencies on aging lack the resources required to guarantee accessible home and community-based care to all who would benefit from it.

Supplemental Security Income. The Supplemental Security Income (SSI) program provides benefits for the indigent aged, blind, and disabled.[129] The Federal Government makes SSI payments to individuals in these categories whose countable income and resources fall below very low limits set by the Federal Government. In theory, SSI benefits are supposed to bring recipients' income up to 75 percent of the federally defined poverty level.

The Federal SSI benefit standard factors in a recipient's living arrangements. If an SSI recipient is living in another person's household (but not the household of a spouse, minor child, or person whose income is deemed to the recipient) and receiving in-kind support [130] from that person, the recipient's SSI benefit is reduced by one-third.[131] In this situation, a caregiver's resources are stretched further to cover care of the older individual. It is possible that the situation created by this policy might exacerbate the tensions of caregiving and contribute to the problem of elder abuse.

2. Quality of Care

At its best, home and community-based care can improve the quality of life for a disabled elder. At its worst, it carries the risk that care recipients might suffer from neglect or abuse at the hands of care providers. Given the great demand for home and

[128] *AoA Report for Fiscal Year 1988,* p. 1.

[129] 42 USC 1381 et seq.

[130] In-kind support is defined as anything that is or could be used to obtain food, clothing, or shelter. 20 CFR 416.1102.

[131] 42 USC 1382a(a)(2)(A); 20 CFR 416.1130-32. When the SSI beneficiary receives in-kind support and the one-third reduction rule does not apply (e.g., because the beneficiary resides at home or in a nonmedical institution), the value of that support is presumed to equal one-third of the Federal benefit rate plus a general income exclusion unless she or he can show that it is worth less than that amount. 20 CFR 416.1140-41. This generally also has the effect of reducing the SSI benefit by one-third.

community-based care and the tremendous growth of the home care industry in recent years, there is a pressing need for effective regulation to protect older persons from poor care and outright abuse.[132] Existing quality control systems include the following: [133]

Federal regulation. **Medicare certification** has long been the principal Federal tool for regulating home care. While certification is a voluntary process for home care agencies, it is a prerequisite for Medicare and Medicaid reimbursement.

OBRA 1987 amended the conditions of participation for home health agencies (HHA).[134] The law, among other things, requires HHAs to safeguard the rights of care recipients. It specifies that patients have the right (1) to have their property treated with respect, (2) to voice grievances regarding treatment or care, and (3) to be advised about the State's toll-free HHA hotline. HCFA regulations implementing the law provide detailed requirements for protection of clients' rights and training and competency of home health aides.[135] States have the option of including in their nurse's aide registries information regarding home health aides who have successfully completed State-approved home health aide competency programs.[136]

States offering home and community-based care as an optional statewide service under Medicaid must certify that participating providers meet certain minimum requirements with respect to individual rights and quality of care.[137] The care recipient is guaranteed the right to be from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in his care plan. States must have procedures for receiving, reviewing, and investigating allegations of individual neglect and abuse (including injuries of unknown source) and misappropriation of an individual's property. Federal and State governments may impose sanctions on providers found to be out of compliance with the law.

State regulation. **Licensure** is the most common regulatory measure at the State level, with licensure laws in effect in 39 States and the District of Columbia. Most licensure laws are very similar to the Medicare conditions of participation and limit coverage to agencies providing skilled nursing care and therapeutic services. Some States enumerate a set of patient/client rights and others specify home health aide training requirements.

Long-term care ombudsman programs, discussed in detail in Chapter IV.B.1, have been expanded to cover home care patients in

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[132] The number of home health agencies certified under Medicare increased by more than 50 percent between 1982 and 1984, reaching a total of 5,237 HHAs by the end of 1984. Sabatino, C., "Home Care Quality: Exploring the Unknown, Part I," *Bifocal,* fall 1986, p. 5. By 1986 there were more than 6,000 Medicare-certified providers, although this number has declined somewhat since then. Noncertified providers number at least 5,000. Sabatino, C., "Home Care Quality," Generations (winter 1989), p. 13.

[133] *See generally* House of Representatives Select Committee on Aging, *The "Black Box" of Home Care,* Comm. Pub. No. 99-573, 99th Cong., 2nd Sess. (1986); Johnson, S., "Quality-Control Regulation of Home Health Care," 26 *Houston Law Review* 901 (Oct. 1989); Sabatino, C., "Home Care Quality," Sabatino, C., "Home Care Quality: Exploring the Unknown," Parts I and II, *Bifocal* (fall and winter 1986); Riley, P., *Quality Assurance in Home Care* (Washington, D.C.: AARP, 1989).

[134] 42 USC 1396bbb.

[135] 42 CFR Part 484.

[136] 42 CFR 483.156(a)(3).

[137] OBRA 1990, P.L. 101-508, 4711(f)-(i).

a number of jurisdictions. The program functions by responding to consumer problems through advocacy and negotiation. It is a promising path to protecting the well-being of home care clients, but it is not without limitations. A significant drawback is that ombudsmen do not have enforcement powers. Furthermore, in States that do not license home health agencies, ombudsmen encounter difficulties in resolving complaints and gathering data on providers.

Other potential sources of State regulation are the various State and local funding sources, such as: (1) Title XX annual service plans; (2) standards for State-funded home care programs; (3) Section 2176 waiver program provider standards; (4) State unit on aging regulations; and (5) area agencies on aging, which may set standards under local grants or subcontracts. Reimbursement-related sources of State regulation differ from one State to another and are nonexistent in some jurisdictions. Thus, they do not constitute a comprehensive or consistent approach to quality of care regulation for the home care industry.

Industry accreditation. Industry accreditation is the only quality-assurance system that is not tied to funding. The Joint Commission on Accreditation of Healthcare Organizations offers its accreditation program to independent and hospital-based home care agencies. The National League for Nursing, in conjunction with the American Public Health Association, and the National HomeCaring Council also have accreditation programs. Accreditation is neither mandatory nor linked to funding, and it is sought by relatively few HHAs.

B. PLANNING FOR THE POSSIBILITY OF INCAPACITY

If an older person becomes mentally or physically disabled, someone else may have to make personal and financial decisions for him or her, as well as provide assistance with the activities of daily life. When these responsibilities fall upon an individual who does not have the elder's best interests at heart, there is a risk that abuse, neglect, or exploitation will occur.

Fortunately there are a variety of devices that enable an individual to plan for maximum autonomy and financial and personal well-being in the event of future incapacity.[138] Joint property arrangements, durable powers of attorney and trusts can help to prevent elder abuse by designating a trusted individual or entity to serve as the substituted decisionmaker. These arrangements minimize the risk that an incapacitated adult will be forced to rely on someone who is inept or untrustworthy. They are preferable to guardianship because they keep the elder's basic rights intact and avoid the stigma of the elder having been adjudged incompetent.

The guiding principle in the use of these planning devices is known as the "least restrictive alternative." This means that:

> [S]ubstituted decisionmaking, whether public or private, should intrude upon personal autonomy only to the extent necessitated by the person's actual impairments and the deci-

[138] Detailed discussions of the full range of surrogate decisionmaking measures may be found in the aforementioned *Guardianship and Alternative Legal Interventions*, and *Protective Services Practice Manual.*

sions actually required. The goal should be to preserve as much as possible the person's ability to decide.[139]

Set out below are descriptions of some of the available planning devices.

1. Joint Property Arrangements

A joint property arrangement exists when two or more persons share ownership of an asset, a bank account, or a piece of real estate.[140] A joint bank account can be useful when one co-owner has limited ability to manage funds because it permits the other co-owner to make deposits and pay bills. It may be a beneficial arrangement when the elder has capacity but is physically unable to go to the bank. There are, however, certain drawbacks. These include the potential for misappropriation of funds by a dishonest co-owner. Depending on the type of joint property arrangement, the co-owner's creditors may be able to obtain funds in the account. If the bank knows that the customer does not have transportation or is not ambulatory it may be too hasty about adding another person's name to the account without thoroughly investigating the circumstances.

2. Powers of Attorney

A power of attorney is an arrangement in which one person, the principal, gives another person, the attorney-in-fact or agent, the authority to act in his place for the purposes set forth in the document establishing their relationship. A special power of attorney limits the agent's powers to those specifically enumerated in the document, and a general power of attorney allows the agent to conduct all business which the principal could conduct by himself. The agent is a fiduciary[141] and therefore can be sued by the principal for acting imprudently or for acting outside the bounds established by the power of attorney.

Traditionally, a power of attorney terminated when the principal became incompetent, but today all 50 States and the District of Columbia recognize the durable power of attorney, which continues to operate after the onset of incapacity. To create a durable power of attorney in most jurisdictions, the document establishing the relationship must contain language that clearly indicates the principal's intent to have the power continue after the onset of disability. A "springing" durable power of attorney can be drafted to take effect only after the principal becomes incapacitated.

The durable power of attorney is a simple and inexpensive way to avoid the need for guardianship or a protective order. It allows an individual to select the person who will make decisions for him

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[139] *Protective Services Practice Manual,* p. 182.

[140] There are various types of joint property arrangements: joint tenancy, tenancy by the entirety (available only to married couples), and tenancy in common. These differ in various respects, such as the right of the creditor of one co-owner to levy upon the joint tenant's interest, the ability of a co-owner to sever the arrangement, and whether, on a co-owner's death, his share passes to his heirs or to the other co-owner. Laws governing these matters vary from one jurisdiction to the next, and it is vital to consult State law before attempting to establish any of these arrangements.

[141] *Black's Law Dictionary,* 6th ed. (Minneapolis, MN: West's Publishing Co., 1990) defines the term "fiduciary" as a "person having [a] duty, created by his undertaking, to act primarily for another's benefit in matters connected with such an undertaking." (p. 625).

after he becomes incapacitated, and to define the scope of that person's powers. Springing powers of attorney are particularly useful in planning for the possibility of incapacity, because they enable the principal to retain control over his or her affairs until incapacity occurs.[142] The fact that the agent is a fiduciary diminishes the chances that he will use the principal's funds for his own ends.

A durable power of attorney is not without disadvantages, notably the potential for abuse by the agent. Although the agent owes the principal a fiduciary duty, he is not under court supervision and his actions will not be questioned unless the principal or a third party raises questions. Since the agent is not bonded, lost assets cannot be recovered if there is dishonesty or wasting of funds. Also, some banks will not recognize a durable power of attorney unless it is set out on their own forms.

3. Trusts

A trust is an arrangement "whereby property is transferred by one person, the grantor (or settlor), for the benefit of another or himself, to be administered or managed by a third party, the trustee, subject to whatever limitations the grantor included in the instrument." [143] A revocable *inter vivos* trust becomes operative during the grantor's lifetime and can be changed or cancelled by the grantor. It can be set up so that if the grantor becomes incapacitated, the trustee can assume management of the grantor's finances and property and use trust funds for the grantor's care.

A trust is an excellent planning device because it allows for professional management of assets if the guardian becomes unable to manage them, and it gives the grantor control over his funds for as long as possible until then. Moreover, the trustee has a fiduciary duty to protect funds and other property in the trust. A primary disadvantage is the expense (i.e., legal fees) involved in establishing a trust.[144] Another is that if a bank's trust department serves as trustee, only the client's financial management is assured because a trust officer is not likely to visit the client's home on a regular basis to monitor his personal and medical needs.

C. MITIGATING THE EFFECTS OF INCAPACITY

1. Money Management Devices [145]

A number of measures are available to assist individuals who have difficulty handling routine financial matters. They minimize

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[142] "The 'trigger' clause of the springing power of attorney should be drafted with great care. If the clause merely states that the power of attorney shall become effective upon the incapacity of the principal, there is serious danger that control will be removed from the principal too soon or too late, or that it will be necessary to turn to the courts for an adjudication of incompetence, which is what the power of attorney is meant to avoid. The principal should carefully consider what criteria he or she wishes to have used in order to bring the power into operation." *Guardianship and Alternative Legal Interventions*, p. SC-33.

[143] *Id.*, p. SC-47.

[144] While traditionally trusts have been used by individuals with extensive assets, the National Conference of Commissioners on Uniform State Laws has proposed the Uniform Custodial Trust Act which would enable low and middle-income people to establish trusts through a simple statement that the trust was created under the provisions of the act. Legal Counsel for the Elderly, *Elder Law Forum*, May/June 1990, p. 7. The Uniform Custodial Trust Act has been adopted by five States: Hawaii, Idaho, Minnesota, Rhode Island, and Virginia.

[145] *See Guardianship and Alternative Legal Interventions*, pp. SC-18, SC-19.

the risk that an elder will become the victim of financial abuse, enable him to retain control over his finances, and can be easily and inexpensively initiated and terminated.

Direct deposit. A person who receives regular income payments, such as Social Security benefits or Supplemental Security Income, may have the checks mailed directly to his or her bank or credit union and deposited into his or her account. This way checks cannot be stolen, misplaced, or destroyed. The bank will mail its customer a record of the deposit. A potential problem is that if a check does not arrive on the same date each month the customer may not know that the money has not been deposited and may write checks with insufficient funds to cover them.

Automatic banking. Many banks can arrange to pay a customer's regular bills.

Billpaying services. For a fee, a money manager or billpaying service may be hired to pay bills and prepare income tax returns.

Utility late payment back-up reporting. Some utilities will not discontinue service due to unpaid bills without notifying one or two persons in addition to the customer. This can be an important safety net for individuals who occasionally forget to pay their bills.

2. Representative Payeeship

A number of government agencies sponsor representative payee programs, in which individuals are appointed to receive Federal benefits on behalf of recipients found incapable of handling the funds.[146] An honest and responsible representative payee can protect an incapacitated elder from others who might seek to obtain his benefits. However, if the representative payee is untrustworthy or inept, she or he can easily become the perpetrator of financial abuse.

Prior to establishing a representative payeeship, a government agency generally receives notice of the beneficiary's alleged need for such an arrangement from an interested third party, such as a friend, relative or nursing home. Based upon its own criteria and regulations, the agency makes a determination of the recipient's ability to manage funds. Before appointing the payee, the agency may notify the beneficiary that a representative payeeship is contemplated.[147] The beneficiary may object and submit evidence on his or her behalf. If no objections are raised, or if the agency determines that the beneficiary is not capable of managing the benefits (there is no requirement that he or she be adjudicated incompetent), it will try to locate a concerned individual or entity to serve as the representative payee.[148] The beneficiary's funds are thereaf-

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[146] The agencies are the Social Security Administration, the Veterans' Administration, the Department of Defense, the Railroad Retirement Board, and the Office of Personnel Management (i.e., Federal retirees).

Representative payee programs are discussed in *Model Standards to Ensure Quality Guardianship and Representative Payeeship Services,* a report of Subcommittee on Housing and Consumer Affairs of the House of Representatives Select Committee on Aging, Comm. Pub. No. 101-729, 101st Cong., 1st Sess. (1989).

[147] Whether notice to the beneficiary is required depends on the agency's regulations.

[148] The representative payee does not have to be a relative of the beneficiary. Agencies' regulations contain guidelines and/or lists indicating who may serve as the payee. The representative payee may be a relative, a friend, or even a stranger. The representative payee may also be an institution, such as a VA hospital or nursing home, or a board and care facility, although this kind of arrangement is precluded under some States' licensure and certification laws.

ter sent to the representative payee who is to use the money only for the beneficiary's needs.

The agency that disburses benefits may monitor the arrangement by requiring the representative payee to make an accounting and by investigating the truth of the report. The arrangement may be terminated if the representative payee fails to use funds on the beneficiary's behalf or misappropriates funds. In such cases, the representative payee may be subject to criminal liability.

Traditionally, Federal agencies have looked to relatives and friends to serve as representative payees, but changing lifestyles have left many beneficiaries without traditional support networks. To help fill this gap, the Social Security Administration's Representative Payee Project seeks to identify individuals and/or organizations to serve as volunteer representative payees.[149] Many successful volunteer representative payee programs have been established in this manner. For example, a large, multiservice center in Seattle, WA acts as representative payee for over 120 clients, and an individual in Tuscaloosa, AL is representative payee to 10 chronically mentally ill individuals. Legal Counsel for the Elderly, a department of the American Association of Retired Persons (AARP) operates a nationwide representative payee project most of whose volunteers are AARP members.

At its best, a representative payeeship is a simple money management device for an incapacitated individual who has few assets and whose income is limited to government benefits. As currently carried out, however, these programs have a number of serious shortcomings:[150]

(1) Representative payeeships offer the beneficiary limited procedural protections.

(2) Since they are not adequately monitored by the sponsoring agencies, representative payeeships can become vehicles for financial abuse.

(3) An agency may suspend payments to a beneficiary after receiving notice of his alleged inability to manage benefits but before appointing a representative payee.

(4) Agencies do not investigate the qualifications of prospective representative payees.

(5) Agencies do not provide remedies for beneficiaries who have been financially abused by representative payees.

In response to these problems, Congress included provisions in OBRA 1990 which are designed to prevent such abuses from occurring in the Social Security Administration's (SSA) representative payee programs.[151] The law, which resulted from a bill introduced by Senator Pryor of Arkansas,[152] Chairman of the Senate Special Committee on Aging, mandates screening and investigation procedures for prospective representative payees. It requires the SSA to

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[149] Administration on Aging, *Information Memorandum AoA-IM-90-22*, "SSA Representative Payee Project," Aug. 24, 1990.

[150] On June 6, 1989, the Senate Special Committee on Aging conducted a hearing that explored the inadequacies of the Social Security Administration's representative payee program. *SSA's Representative Payee Program: Safeguarding Beneficiaries From Abuse*, S. Hrg. 101-182, Serial No. 101-5, 101st Cong., 1st Sess. (1989).

[151] Public Law 101-508, 5105.

[152] The bill, S. 1130, was introduced in the 101st Congress.

conduct criminal background checks on representative payee applicants and to verify their identities. If the SSA is unable to locate an appropriate representative payee and finds that direct payment to the beneficiary would cause him or her substantial harm, benefits may be withheld for no more than 1 month. SSA is required to repay individuals whose benefits are lost due to the agency's negligence in appointing or monitoring a representative payee and to make a good faith effort to seek restitution of misused funds. The law precludes a beneficiary's creditors (with some exceptions) from serving as his or her representative payee. SSA is also mandated to study and make recommendations on (among other things) the feasibility of (1) formulating stricter accounting requirements for high risk representative payees and providing for more stringent review of all accounting from such individuals; and (2) establishing and maintaining a list of individuals convicted of Social Security or SSI check fraud violations to be used in assisting claims representatives in their investigations of representative payee applicants.

D. OLDER AMERICANS ACT PROGRAMS [153]

Title III of the Older Americans Act has long been an important source of funding for several key elder abuse prevention activities:

(1) *The long-term care ombudsman program,* discussed in Section IV-B-1.

(2) *In-home care (e.g., respite care, homemaker services),* discussed in Section V-A-1.

(3) OAA moneys support over 600 local *legal programs for the elderly in greatest social and economic need.*[154] Clients are often abuse victims needing assistance from or representation by the programs' attorneys, paralegals, and lay advocates. These legal service providers handle matters such as guardianships, protective services, nursing home problems, representative payee matters and protection orders for abused and at-risk elders.

Due to insufficient resources, OAA-funded legal services programs provide only a partial answer to abuse victims and other older persons in need of legal representation:

> Older Americans Act funds are limited, and legal assistance must compete for Title III dollars with other critical social services. . . . In spite of the Older Americans Act priority on legal assistance, many States devote less than 5 percent—and some less than 2 percent—of their Title III social services funds to legal assistance. Moreover, that "legal assistance" is often primarily an educational, referral or lay advocacy project, rather than representation by an attorney.[155]

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[153] 42 USC 3027(a)(12).

[154] 42 USC 3027(a)(15). OAA legal services programs are discussed in *Developments in Aging: 1989, Volume 1,* pp. 386–387, 394–395.

Legal Services Corporation (LSC) programs are geared to meeting the legal needs of the poor, of which the elderly are a significant proportion. LSC attorneys do their primary representation of elderly clients in Government benefit programs such as Medicare and Social Security.

Unlike OAA legal services programs, which prohibit means testing to determine eligibility, LSC eligibility generally is limited to individuals whose income is no higher than 125 percent of the established poverty level. *See id.*, pp. 384–386, 388–394. There are, however, many LSC projects which receive Title III funding, and these can serve elderly clients who are above the stringent LSC poverty limits.

[155] American Bar Association, *Legal Services for the Elderly: Where the Nation Stands,* 4th ed. (1988), p. 9.

Since OAA legal programs normally target their scarce resources to clients in crisis situations, "advance legal planning to help older persons maximize their autonomy in the event of disability is often simply left out."[156]

The need for legal services for actual and potential elder abuse victims is critical. The OAA and other programs which provide these services deserve sustained, if not enhanced, Federal support.

(4) The 1987 Older Americans Act Amendments (P.L. 100–175) included a distinct authorization of funds for *services to prevent abuse, neglect, and exploitation of older individuals* under a new Part G of Title III.[157] Public Law 100–175 authorized $5 million in fiscal year 1988 and such sums as may be needed for each of fiscal years 1989–91 for elder abuse prevention services. Congress appropriated $2.9 million for this program for fiscal year 1991. It was the first time that program received any of its authorized funding.[158]

Part G requires each State to: (1) Establish a program for the prevention of abuse, neglect, and exploitation of older individuals; (2) provide public education, outreach services, and information and referral services; (3) receive reports of abuse and neglect; and (4) refer complaints to law enforcement agencies and other appropriate local and State agencies. The law prohibits involuntary or coerced participation by alleged victims, abusers, or their households.

In creating Part G, Congress was concerned that OAA elder abuse prevention programs should not conflict with existing State law:

> The Conferees recognize that the laws of some States give authority over elder abuse prevention and protection to agencies outside of the aging network. The Conferees intend that the requirements of this section be carried out strictly within the confines of pertinent State laws. Area agencies on aging are expected to use these funds to complement and supplement, not duplicate, existing elder abuse prevention and protection programs.[159]

The law therefore mandates coordination of the aging network's elder abuse prevention programs with State APS activities and other State and local elder abuse programs.[160] Nevertheless, there is concern that State units on aging may use Part G funds to create programs that are superfluous to or competitive with existing APS programs. Furthermore, even if the fully authorized $5 million were to be appropriated, when divided among 670 area agencies on aging the sums allotted are too small to fund any kind of meaningful activity.

To make the most effective use of funds appropriated for the OAA elder abuse prevention program, Senator Adams of Washing-

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[156] *Id.*

[157] 42 USC 3030p.

[158] Congress sought to protect existing OAA programs through a funding trigger that prohibits appropriations of funds for the newly authorized programs (except for the Title D program, "In-Home Services for the Frail Elderly") unless tctal appropriations for the programs in effect in fiscal year 1987 increase by at least 5 percent. 42 USC 3023(h). This did not occur until fiscal year 1991.

[159] House Conference Report No. 100–427, to accompany H.R. 1451, 100th Cong., 1st Sess., (Nov. 9, 1987), p. 77.

[160] 42 USC 3030p(1).

ton and Senator Harkin of Iowa made two proposals during the 1991 appropriations process. First, the States should be given maximum discretion in the allocation of Part G funds. Second, some portion of the Part G appropriation should be made available to the States' ombudsman programs.[161] Their proposals were adopted in the conference report.[162] However, on advice from the Office of General Counsel, the Administration on Aging has opted to disregard the conferees' recommendations and will require the States to allocate Part G moneys based on traditional allocation formulas.

In addition to the programs authorized under Title III, the aging network plays an elder abuse prevention role through its cooperation with the States' APS programs. A recent study found a high level of cooperation between the States' aging networks and their APS agencies:

> First, for the most part, and in many States, State aging personnel are supportive of the APS system. They provide training and education to assist the APS program staff in maintaining current information about the sub-state services available to older people through the aging network. They promote the use of new strategies for assessing the needs/abilities of the elderly, and they develop methods for local coordination through committees and task forces which concentrate on the development of new resources and services. . . .
>
> Second, area agencies on aging play an important role in the APS program as support service managers. Case management, in-home services and legal assistance are among the most frequently funded SUA/AAA services provided to APS clients.[163]

Noting that more than half the caseload of APS agencies consists of persons over 60 years of age, the report suggested that in States with separate APS and aging network administrations,[164] "the aging network must take into account the services provided by APS agencies and plan with them as the overall picture of needs and service capacities in the State are assessed."[165] Formal interagency planning may contribute to improvements in the delivery of service to the vulnerable elderly, and maximize the effect of resources currently available to APS programs and the aging network.

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[161] Congressional Record, Oct. 12, 1990, S. 15086–7.

[162] "It is the expectation of the conferees that the States be given discretion in the allocation of the elder abuse funds so as to provide for the most effective elder abuse prevention efforts. It is further the conferees' expectation that portions of the elder abuse funds will be made available to State long-term care ombudsman programs to address complaints of abuse in long-term care facilities, including board and care homes." Conference Report to accompany H.R. 5257, Report No. 101-908, 101st Cong., 2nd Sess (Oct. 20, 1990), p. 29.

[163] *Adult Protective Services: Programs in State Social Service Agencies and State Units on Aging*, p. 240.

[164] In the majority of jurisdictions the APS agency and the SUA are administered by separate departments. There are other jurisdictions in which the SUA and the APS agency are administered in one department by either one or two organizational units. In a few States, the SUA administers services for impaired older persons which may be similar to APS programs in other States.

[165] *Adult Protective Services: Programs in State Social Service Agencies and State Units on Aging*, p. 242.

SECTION VI. TARGETING INTERVENTION STRATEGIES TO SPECIAL POPULATIONS

There is little documentation on the subject of elder abuse in minority communities, its prevalence or causes. NARCEA indicates that racial data is infrequently collected on the reported victims of elder abuse, and States collecting racial data collect it inconsistently. However, if previously cited figures hold true for all communities, 1 out of 20 minority elders may be victimized annually.[166]

In 1980, over 2.5 million elders, ages 65 and above, were identified as racial and ethnic minorities.[167] If current population trends persist, by the year 2020 the number of African American elders may double to 5.5 million,[168] and the number of Hispanic elders quadruple to 4 million [169] based upon rates projected by the Bureau of the Census. An increasing longevity for all Americans will result in the growth of the racial and ethnic populations of minority elders.

National data collection methods have commonly identified respondents by race: White, Black, American Indian, Asian and Pacific Islander, and Spanish origin. However, this traditional scheme does not capture the cultural heterogeneity of the ethnic minority population. The phrase "Asian and Pacific American", for example, describes individuals from 32 distinct cultural backgrounds.[170] Native Americans originate from approximately 400 different tribes.[171] The African American and Hispanic populations are similarly diverse in their cultural compositions. Variations in language preference, in the historical circumstances surrounding immigration, and rates of assimilation further contribute to the exceptional heterogeneity of the nation's elder minority group.

It is frequently assumed that ethnic minority elders are foreign-born if they speak English with an accent, or chose to speak a language other than English. Some providers use the phrase "foreign-born" to refer to these individuals in an effort to be culturally sensitive. However, in many cases the term is used inaccurately. Lan-

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[166] *Elder Abuse: A Decade of Shame and Inaction*, p. xi.

[167] Departmentof Commerce, Bureau of the Census PC80-1-B1, General Population Characteristics, U.S. Summary: 1980; Tables 38, 43, 46, and 47.

[168] Projections of the Population of the United States by Age, Sex and Race: 1988 to 2080, Current Population Reports, Population Estimates and Projections Series P-25, No. 1018, U.S. Department of Commerce, Bureau of the Census.

[169] Projections of the Hispanic Population: 1983 to 2080, Current Population Reports, Population Estimates and Projections, Series P-25, No. 995, U.S. Department of Commerce, Bureau of the Census.

[170] Tomita, Susan K., School of Social Work, University of Washington, "The Consideration of Asian Cultural Factors in the Research of Elder Mistreatment with an In-Depth Look at the Japanese", an unpublished paper prepared for a National Institute on Aging Workshop on *Family Conflict and Elder Abuse*, May 2-3, 1991, Bethesda, MD.

[171] Carson, David K., et al, "Stresses and Strengths of Native American Reservation Families in Poverty", Family Perspective, Vol. 24, No. 4, 383-400, 1990.

guage preference does not indicate country of origin.[172] The majority of the current population of racial and ethnic minority elders have always been U.S. citizens, and this citizenship is frequently a source of great pride. Many would prefer to have their race, ethnicity, and citizenship clearly acknowledged by providers and others; for example: African American, Korean American, Cuban American, Native American.

A. TARGETING OF ABUSED ETHNIC MINORITY ELDERS

In the absence of confirmed data, it is assumed elder abuse in minority communities mirrors the range of abuse observed within the non-minority population. Abusive behaviors as previously defined include the physical, psychological, or financial abuse of the aged, neglect by a caregiver, and self-neglect and abuse. The prevalence of one form of abuse over another may vary between ethnic groups, as may the abusive behaviors within a given category. For example, where psychological abuse might include the use of verbally aggressive statements in one culture, it may include the use of silence in another.[173]

As indicated in the previous section, Title III of the OAA mandates the targeting of social services to elders in "greatest social need". The OAA has defined this group to include racial and ethnic minorities who face language barriers and isolation due to cultural, noneconomic factors.[174] In the provision of service to the ethnic elderly under the OAA, there is precedence for recognizing social isolation as a special problem for this population.

However, with the exception of the OAA and recent amendments proposed to it, the targeting of ethnic minorities does not carry over into proposed and existing Federal legislation and appropriations designed to combat elder abuse, despite evidence that social isolation contributes to the potential for the abuse and neglect of the elderly.

In a related matter of concern to some advocates for ethnic minority elders, several OAA provisions are based upon a significant and possibly flawed assumption. The elder abuse prevention activities mandated under the OAA include:

> Public education and outreach services to identify and prevent abuse, neglect, and exploitation of older individuals; and
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> Active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social agencies or sources of assistance if appropriate. . .[175]

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[172] For example, a national needs assessment conducted with Hispanics revealed that, of Mexican Americans, "the majority (55%) of aging U.S. Mexicans surveyed were born in the United States rather than in Mexico, with 25% of the older Mexican-born immigrants reporting that they migrated to the United States before the age of 26; only a few (5%) reported migrating to the United States after the age of 50 . . . 86% of the respondents chose to be interviewed in Spanish." Harper, M.S. (Ed.). (1990). *Minority Aging: Essential Curricula Content for Selected Health and Allied Health Professions.* Health Resources and Services Administration, Department of Health and Human Services. DHHS Publication No. HRS (P-DV-90-4). Washington, D.C.: U.S. Government Printing Office, p. 377.

[173] "The Consideration of Asian Culture Factors in the Research of Elder Mistreatment", p. 15.

[174] 42 USC 3025(a)(2)(E).

[175] Older Americans Act, Sec. 371(2) (A) and (C).

These mandates assume that aging network and APS personnel will be able to interact and communicate effectively with all elders, an assumption which may not be borne out in fact.

In the absence of formal provisions for those with special needs, it has been argued that adult protective services are not consistently structured to identify and respond to victims who are racially and culturally different and who do not speak English. APS and aging network personnel, and assisting staff from law enforcement and the judicial system may not have the requisite language and cross-cultural skills to communicate productively with victims and their families. Abused minority elders may often be illiterate in a first language, as well as English, which will render outreach through the use of translated, printed material ineffective. It has also been suggested that several recognized instruments used to measure familial violence may not reveal abuse as it is manifest in other cultures, and in particular Asian culture.[176] Elder abuse is frequently familial abuse.[177]

As currently conceptualized, the APS model appears to lack a mechanism for the adjustment of methods commonly used to diagnose and intervene in cases of elder abuse where ethnic diversity is a factor.

B. PRESCRIPTIONS FOR INTERVENTION

Where a formal mechanism does not exist, effective adult protection will require cultural sensitivity from advocates for the abused minority elderly. The following observations are drawn primarily from the literature of cross-cultural counseling.

1. **Respond to "[t]he client's definition and understanding of an experience as a problem":**[178] "Abuse" is defined within a cultural context. What may appear to be abusive behavior to members of the majority may not be considered abusive to those of other cultural orientations. And in converse, behaviors which may not be diagnosed as abusive within the cultural context of the majority may be experienced by others as abuse.

To choose an example of each, NARCEA estimates that financial abuse was the fourth most common form of elder mistreatment in 1988.[179] However, "financial abuse" as defined by majority consensus[180] may not be experienced as abusive behavior by members of all ethnic groups. Or it may be experienced to a lesser degree. The pooling of financial resources for the common use of members of an extended family or support network is the rule in some ethnic groups. A designated individual makes financial decisions for the group and this process is regarded as good.[181] Conversely, in a society which tends to define abuse in terms of physical and verbal aggression (hitting, shouting, taking away, etc.), the intentional use of

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[176] "The Consideration of Asian Culture Factors in the Research of Elder Mistreatment", p. 21.

[177] *Elder Abuse: Questions and Answers*, p. 7.

[178] Green, James W., "Help-Seeking Behavior", *Cultural Awareness in the Human Services*, Prentice-Hall Series in Social Work Practice, 1982, p. 32-36.

[179] *Elder Abuse: Questions and Answers*, pp. 5-6.

[180] Where financial abuse or exploitation is defined by the OAA as "the illegal or improper act or process of a caretaker using the resources of an older individual for monetary or personal benefit, profit or gain," Older Americans Act, Sec. 302(17).

[181] "The Structure of the Black Community: The Knowledge Base for Social Workers", *Cultural Awareness in the Human Services*, p. 113.

silence to punish may go undiagnosed.[182] In other cultures, exclusion from the flow of family life and conversation may be experienced as the annihilation of self,[183] and therefore a fundamental bad.

When attempting intervention, allow potential clients to interpret the "goodness" or "badness" of their living situations, in the language in which they are most comfortable, matching the age and gender of staff person and client when possible. Given the sensitive nature of the subject, choose translators wisely when required. Untrained support staff, although bilingual, and family members of the victim are usually inappropriate choices for translation service.

In some cultures, there is a given amount of sacrifice and suffering that is accepted and expected in the course of life. The concept of normative suffering is particularly ingrained in the women and mothers of some ethnic backgrounds. In some cases, there is a spiritual dimension associated with this phenomena where suffering is attributed to the will of God. This may have implications for the evaluation of some ethnic minority clients as the typical abuse victim is both a woman and a mother. Rather than attempting to acculturate the client to "more progressive" ways of thinking, the advocate should respect the ethnic client's culturally based beliefs and aim to relieve the unhappiness that exceeds client expectations.

It has been proposed that professional and public awareness is the most effective means of identifying the victims of elder abuse.[184] Ethnic minority elders may visit physicians more often than they visit therapists, social workers or other professionals. It is said of this population that "[i]n the health field, . . . behaviors translate into going to the family physician or the health clinic for the treatment of affective dysfunctions such as depression, bypassing the mental health service." [185] Thus, health care professionals should be aware of research on traditional cultures which has shown that emotional pain is frequently expressed in somatic, physical terms.[186] It may be more acceptable to express physical pain than the depression or anxiety which may result from abuse.

2. Tailor the intervention style to the cultural norms of the client you want to help. Formal, legal intervention may be less effective than a home and family-based intervention program.

The understanding of self and of family is central to the reasoning in the examples posed above. In some cultures, adults think of themselves first as individuals and later as members of family and society. In others, it is through continuing participation in a group, and usually an extended family, that a sense of self is developed and maintained. To broadly generalize, in many ethnic minority groups the family defines, supports, and to varying degrees, supercedes the individual.

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[182] "The Consideration of Asian Culture Factors in the Research of Elder Mistreatment", p. 21.
[183] *Id.* pp. 9–10.
[184] *Elder Abuse: The Effectiveness of Reporting Laws*, p. 5.
[185] *Minority Aging*, p. 437.
[186] *Ibid.*

The power of the family in ethnic communities is widely documented,[187] although the role of extended family is diminishing in Mexican American[188] and Native American communities,[189] and has been fractured by immigration in others.[190] Elder abuse victims are frequently women, and in conjunction with self-definition, the traditional ethnic family exerts a powerful force on the sex-role definition of women.[191] Women from some ethnic backgrounds may be hesitant to move beyond the extended family for help in times of crisis. In a recent study to identify the social service needs of Chinese, Filipina and Latina immigrant women, of a total of 413 survey participants, 20 percent reported familial violence, and of these, only 1 had "ever gone outside her family/friendship network, in calling the police and in talking with a social worker."[192] The fear of deportation played a significant role in the low service usage documented here. Language barriers may have also been prohibitive. However, the relatively subordinate position of women in some traditional ethnic families may have contributed as well. As one Filipina associated with the study said

> "In the Philippines there is a value. Women are great sufferers. You have to wash your linen in your own house. Men can be involved with many 'extracurricular activities' but not women. About the violence, it is accepted in a way—but not talked about outside the family. There is no law to protect the woman. You do not call the police. It is a family secret, a no-no."[193]

Ethnic minority elders are usually cared for in the context of family. They are consistently less likely to live alone, or in nursing homes, than elderly Whites.[194] A 1987 study of the elderly in Black, Chinese, White, and Mexican communities indicates that the assistance of elderly parents is most likely to occur when the family has experienced less acculturation: "The closer the ties to traditional culture, the greater the parent-child supportive behavior."[195]

The family unit provides both material support and, as indicated, a continuing sense of identity. For these reasons, an ethnic elder who is experiencing pain due to mistreatment by a family caregiver may be hesitant to discuss the mistreatment. Fear of the loss

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[187] For reference to a broad range of authors and for substantive information on ethnic families, see Kumabe, Kazuye T., et al., *Bridging Ethnocultural Diversity in Social Work and Health*, University of Hawaii School of Social Work, 1985; Sue, Derald W., et al., *Counseling the Culturally Different: Theory and Practice*, John Wiley and Sons, NY, 1981; Sue, D.W., and Sue, D., *Counseling the Culturally Different: Theory and Practice*, John Wiley and Sons, NY, 1990; and *Ethnic Families in America: Patterns and Variations*, Elsevier Science Publishing Co., Inc., Third Edition, 1988.

[188] Williams, Norma, *The Mexican American Family: Tradition and Change*, General Hall, Inc., NY, 1990, p. 137.

[189] Carson, David K., Child and Family Studies Program, University of Wyoming, Laramie, WY, "Native American Elder Abuse? Risk and Protective Factors Among the Oldest Americans", an unpublished paper prepared for a National Institute on Aging workshop, *Family Conflict and Elder Abuse*, May 2-3, 1991, Bethesda, MD, p. 5.

[190] Hogeland, Cris and Rosen, Karen, *Dreams Lost, Dreams Found: Undocumented Women in the Land of Opportunity*, A Survey Research Project of Chinese, Filipina and Latina Undocumented Women, Immigrant Women's Task Force, Coalition for Immigrant and Refugee Rights and Services, San Francisco, CA, 1991.

[191] See *The Mexican American Family*, and *Minority Aging*, p. 438.

[192] *Dreams Lost, Dreams Found*, p. 49.

[193] *Dreams Lost, Dreams Found*, pp. 48-49.

[194] *A Portrait of Older Minorities*, AARP Minority Affairs Initiative, American Association of Retired Persons.

[195] *Minority Aging*, p. 304.

of material support may be common to all communities. But a subconscious resistance to the loss of identity through an involuntary separation from the group, and the unwillingness to "betray the group"[196] or to expose the family or supporting network to "the tremendous social shame and stigma attached to victimization (for both the victim and the perpetrator)",[197] may be unique deterrents to the reporting of abuse among minority elders.

In some ethnic groups, the elderly may neither trust government nor independently choose to use its services. Some fear the legal system due to poor past experience with law enforcement in this and other countries, or due to their undocumented status or the undocumented status of family members. In these cases, to press legal remedies upon a victim afraid to accept them, or to initiate a possible separation from the family group, will not be helpful. Elder mistreatment is frequently elder neglect. When help is requested, it may be preferable to offer the option of in-home assistance with nutrition, the tasks of daily living, and socialization services. As a less intrusive alternative, this may improve the quality of life for an elder in need, within the cultural context of family and community, and without the assignment of blame. At times, the family as a whole will expect to participate in the decisionmaking surrounding the elderly member.[198]

Elder abuse is a national problem, and Federal and State laws may contribute to its solution by reducing the overall frequency of abuse. But at the most fundamental level, a solution to the problem of elder abuse is developed on a case-by-case basis, is client specific and geared to the needs of individual elderly persons. Two of the most basic of tools in the advocate's arsenal are the ability to speak with the abused in a language which the abused understands, and the ability to interact with victims productively. The use of all other tools, including legal remedies, follows the use of these basic tools. It is assumed that advocates for the abused elderly have the language and inter-relational skills required to assist all abuse victims, but given the multi-ethnic composition of some jurisdictions, this assumption may be questioned. Where the most basic of advocacy tools do not exist, in the interests of equity and compassion, provisions must be made for their development.

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[196] "The Consideration of Asian Cultural Factors in the Research of Elder Mistreatment", p. 16.
[197] "Native American Elder Abuse?", p. 9.
[198] In the context of medical care, see *Minority Aging*, pp. 393–394.

SECTION VII. PROSECUTION

A. TORT ACTIONS

Tort actions may be instituted against care providers whose abusive or neglectful care causes an elder's injury, financial loss, or death. While most of the pertinent reported cases involve litigation against hospitals [199] and nursing homes,[200] the future may bring more litigation of this kind against other types of providers, such as home health agencies,[201] board and care facilities, and adult day care centers.

In cases of physical abuse, actions for assault and battery may be viable.[202] If an individual has been restrained or otherwise confined against his will, an action for false imprisonment [203] may be appropriate, "providing as it does specific protection of . . . a basic freedom or right." [204] In cases of financial abuse, an action for conversion of property may provide redress with such potential remedies as imposition of a constructive trust on the defendant's assets and restitution of misappropriated funds.[205]

A negligence or malpractice action may be based on a provider's failure to meet the standard of care, skill, and diligence used by similar providers in the community. Providers are also held to standards of care found in Federal and State law. For example, Federal and State law govern nearly all aspects of hospital and nursing home activities, and violations of these may be used to establish a violation of the standard of care. Facility policies, accreditation standards, and patient bills of rights may also serve as proof of the standard of care.

In a negligence case, it must be established that the provider's acts or omissions proximately caused the elder's injury.[206] If such

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[199] *See, e.g.*, "Hospital's liability for injuries sustained by patient as a result of restraints imposed on movement," 25 ALR3d 1450; "Hospital's liability for patient's injury or death as result of fall from bed," 9 ALR4th 149.

[200] *See, e.g.*, Johnson, S., Terry, N., and Wolff, M., *Nursing Homes and the Law: State Regulation and Private Litigation* (Norcross, GA: The Harrison Company, 1985) (hereafter *Nursing Homes and the Law*); Nemore, P., "Protecting Nursing-Home Residents: Tort Actions Are One Way," *Trial*, Dec. 1985, pp. 54–61; *Aging and the Law*, pp. 534–541; "Patient tort liability of rest, convalescent, or nursing homes," 83 ALR3d 871.

[201] *Roach* v. *Kelly Health Care, Inc.*, 87 Or. App. 495, 742 P.2d 1190 (1987), is apparently the only reported cased involving a personal injury claim by a patient against a home health agency. The case is analyzed in Sandra Johnson's article, "Quality-Control Regulation of Home Health Care," 26 *Houston Law Review* 901, 917 (Oct. 1989).

[202] *Nursing Homes and the Law*, § 3-9. "[B]attery involves an intended harmful or offensive contact and assault merely the imminent apprehension of such a contact." *Id.*, p. 77.

[203] "False imprisonment consists in the unlawful detention of the person of another, for any length of time, whereby he is deprived of his personal liberty." *Black's Law Dictionary*, p. 757.

[204] *Nursing Homes and the Law*, § 3-11, p. 80.

[205] *Id.*, § 3-14; "Protecting Nursing-Home Residents: Tort Actions Are One Way," p. 56.

[206] Proximate cause is the legal term referring to "[t]hat which, in a natural and continuous sequence, unbroken by any intervening cause, produces injury, and without which the result would not have occurred." *Black's Law Dictionary*, p. 1225. In criminal and tort law, one's liability is generally limited to results proximately caused by his act or omission.

causation is not common knowledge, then expert testimony may be required to establish that failure to meet the standard of care is the proximate cause of the injury. Nurses, for example, may be needed to testify about the care and treatment of bedsores.

When causation and damages are established, damage awards can be significant. In a recent suit against a nursing home, a jury awarded $250,000 in compensatory damages and $250,000 in punitive damages to the relatives of residents who were neglected but did not suffer serious injury or death.[207] The largest verdict ever against a nursing home, $39.4 million, was recently awarded to the family of an 84-year-old resident who was strangled to death by a restraining device.[208] Verdicts such as these reflect the public's increasing indignance at institution-based abuse and neglect of the elderly.

While elder abuse would seem to be a popular area for tort litigation, there are relatively few reported cases. This is due primarily to the many factors that make it difficult to win such an action:

The elder may die before the case comes to court, possibly as a direct result of the abuse or neglect. In some States, certain types of action are deemed purely personal, so the tort action would not survive the potential plaintiff.

For those causes of action that do survive, juries may be unwilling to award damages to family members, particularly those thought to have been undevoted to the deceased.

If the elder is alive, she may have memory or communication problems that make her a poor witness, and this problem may be shared by other elders who are potential witnesses.

Nursing home residents and their families may fear retaliation if they sue the facility.

It may be difficult to establish causation, since an elderly person's physical frailty may create a plausible defense that the injury was not caused by the provider's actions or omissions.

Proof of damages may pose a problem. Since many elderly persons, especially those receiving long-term care, do not have earning power, it is not possible to cite lost wages or profits as a way of measuring damages. Moreover some States limit punitive damages and pain and suffering awards in survival and wrongful death actions.

Older people simply do not file negligence suits at nearly the rate of younger people. Empirical research has revealed that the probability of an elderly person's filing a malpractice claim, given a potentially actionable injury, is roughly one-fourth that of persons under the age of 65.[209] In view of the hurdles to successful litigation, this is not surprising.

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[207] *Bolian* v. *Beverly Enterprises* (U.S. Dist. Ct., S. Dist. Miss., Civ. A. No. J86-0090(W)) and *Berryhill* v. *Beverly Enterprises* (U.S. Dist. Ct., S. Dist. Miss., Civ. A. No. J86-0084(W)). It was alleged that the residents were neglected by being left to lie in their own feces and urine. There was also testimony that one of the residents suffered verbal abuse and physical abuse that left a bruise on his forehead and marks on his chin. *NAELA News*, Vol. II, No. 3, Apr. 1990, p. 3; *Senior Law Report*, Mar. 21, 1990, p. 1. The *Bolian* case was reopened in Aug. 1990 when the judge granted the defendant's motions for judgment notwithstanding the verdict and for a new trial. The parties subsequently settled and the case was dismissed in Jan. 1991.

[208] *Bauman* v. *Seven Acres Jewish Geriatric Center*, discussed in *NAELA News*, Vol. II, No. 3, Apr. 1990, p. 3 and *Senior Law Report*, Apr. 4, 1990, p. 1.

[209] "The Fear of Liability and the Use of Restraints in Nursing Homes," p. 264.

Many States have enacted statutory private rights of action to overcome some of the obstacles to successful tort litigation against nursing homes. "These statutes typically provide enhanced damages for violations of State licensure standards" and are intended to improve the quality of nursing home care by creating "private attorneys general" for the enforcement of State standards.[210]

In the nursing home arena, Federal and State law regarding Medicaid eligibility may pose a serious disincentive to potential tort litigants: nursing home residents who receive Medicaid benefits risk the loss of eligibility, which is based on financial need, if they receive a sizeable damage award.[211] Ironically, any damages received as a result of a lawsuit may have to be paid to the nursing home that caused the harm until the money is used up. To avoid this problem, some States' laws provide that damage awards do not affect Medicaid eligibility.[212] In other States, it may be possible to invest the award in exempt assets in order to maintain Medicaid eligibility.

When the tort statute of limitations has run and the contract statute of limitations has not, the case may have to be framed as a contract action.[213] Potential nursing home residents and home health agency clients (or their legal representatives) typically sign a contract with the care provider. The types of behavior complained of in a tort action, such as failure to provide adequate nursing care or food, typically also constitute a breach of contract.

B. CRIMINAL PROSECUTION

The criminal justice system provides another avenue of assistance for the elder abuse victim, who may choose to press criminal charges against his abuser. A perpetrator of physical abuse may be charged with one of various forms of assault, battery, reckless endangerment, or intent to commit murder. For financial abuse, a perpetrator may be charged with theft, burglary, blackmail, extortion, forgery, or possession of stolen property.[214] Some jurisdictions have enacted laws which enhance the penalty for crimes committed against the elderly.[215] For example, in the District of Columbia, robbery, attempted robbery, theft, attempted theft, extortion or fraud perpetrated against a victim over the age of 60 all carry a fine and imprisonment of up to one and a half times the normal penalty.[216] A number of jurisdictions impose criminal penalties for abusive actions taken by family members and other caregivers of elderly and dependent adults.[217] Under Illinois law, "criminal neglect of an elderly or disabled person" is a felony. This crime occurs when a caregiver:

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[210] "Quality-Control Regulation of Home Health Care," p. 920.

[211] "Protecting Nursing-Home Residents: Tort Actions Are One Way," p. 59.

[212] *E.g.*, New York Public Health Law § 2801-d(5).

[213] *Aging and the Law*, pp. 539-540; "Quality Control Regulation of Home Health Care," p. 914.

[214] *See generally* Lupinski, L., "Elder Abuse: A Pressing Need for Federal Assistance," pp. 145-148; Quinn, M.J. and Tomita, S.K., *Elder Abuse and Neglect*, pp. 219-222.

[215] *Law and Aging*, pp. 353-356.

[216] D.C. Code Ann. § 22-3901.

[217] *Law and Aging*, pp. 356-357.

(1) Performs acts which cause the elderly or disabled person's life to be endangered, health to be injured, or pre-existing physical or mental condition to deteriorate; or

(2) Fails to perform acts which he knows or reasonably should know are necessary to maintain or preserve the life or health of the elderly or disabled person and such failure causes the elderly or disabled person's life to be endangered, health to be injured, or preexisting physical or mental condition to deteriorate.[218]

Still other States impose criminal liability for abuse of institutionalized persons who are old or infirm.[219]

In some communities, the criminal justice system—prosecutors, police, and judges—have responded aggressively and creatively to the victimization of older persons. For example, the District Attorney's office in Middlesex County, MA has implemented an "Action Plan for Crimes Against the Elderly." [220] The plan includes: (1) a coordinated multidisciplinary response to cases of elder abuse; (2) priority prosecution and special handling of street and violent crime cases involving older victims; (3) white collar prosecution of economic crime and financial exploitation of elderly citizens; (4) public education and elder abuse training for APS workers, police, and professionals; and (5) crime awareness and prevention programs designed to prevent the victimization of older persons. In Oakland, CA, the police department has discovered and referred to legal services attorneys numerous cases of elderly homeowners being victimized by family members who had moved in to conduct illicit drug activities.[221]

> If an abused or exploited elder chooses to press charges and succeeds, the offender may be sent to jail where he or she cannot victimize the elder. Pressing charges can have other advantages:

In some instances it may be helpful for the victim to have charges pressed in order to help the wrongdoer obtain court-mandated counseling. When pressed charges result in a conviction, the wrongdoer may also be mandated to make restitution to the victim for medical care and property loss or destruction. The wrongdoer may also be ordered to have no more contact with the victim, thus providing a safer situation for her. The wrongdoer may be deterred

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[218] Ill. Ann. Stat. Ch. 38, Para. 12-21. Similarly, under Indiana law, "neglect of a dependent" is a felony. This crime occurs when a caregiver of a dependent adult intentionally or knowingly places the dependent in a dangerous situation, abandons, or "cruelly confines" the dependent, or deprives the dependent of necessary support. Ind. Code § 35-46-1-4.

[219] *Aging and the Law,* pp. 357-359; "Criminal liability under statutes penalizing abuse or neglect of the institutionalized infirm," 60 ALR4th 1153. Under these statutes, facilities and their employees have been convicted for failure to provide residents with sufficient food; failure to keep residents clean, or to prevent bedsores from occurring; and use of physical force to compel residents to submit to searches.

[220] House of Representatives Select Committee on Aging, Subcommittee on Health and Long-Term Care, *Hearing, Elder Abuse: A Decade of Shame and Inaction,* Comm. Pub. 101-768, 101st Cong., 2nd Sess. (May 1, 1990) (Testimony of and supplemental material submitted for the record by Scott Harshbarger, District Attorney, Middlesex County, MA).

[221] Senate Special Committee on Aging, *Our Nation's Elderly: Hidden Victims of the Drug War,* S. Hrg. 101-903, Serial No. 101-13, 101st Cong., 1st Sess. (Nov. 15, 1989) (testimony of Robert Crawford, Sergeant, Oakland, CA Police Department).

from committing further abusive acts if she knows that she may be arrested and charged.[222]

Despite these potential benefits, relatively few cases of elder abuse and exploitation actually reach the criminal courts. In part this is due to victims' reluctance to ask that charges be pressed when the abuser is a relative, as is often the case. Having to testify in court about the fraud or abuse may be traumatic, and therefore the victim may refuse to participate in criminal proceedings. Prosecutors themselves may be reluctant to proceed with a criminal action when the victim's failing memory would render his or her testimony less than credible.

If the elder presses charges she or he may face new problems, such as increased antagonism by the perpetrator who may retaliate with more abuse.[223] If the abuser is the elder's main caregiver and is sent to prison, the elder must then find a new caregiver or living situation. Thus, while the criminal justice system is a tool for the advocate of abused elders, it cannot provide all the answers.

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[222] *Elder Abuse and Neglect,* p. 221; *see also* Harshbarger, S., "A Prosecutor's Perspective on Protecting Older Americans: Keynote Address," *Journal of Elder Abuse & Neglect,* Vol. 1, No. 3 (1989), pp. 5-15.

[223] In such instances, it may be necessary to obtain a restraining order.

SECTION VIII. POLICY RECOMMENDATIONS

To alleviate the problem of elder abuse, legislators and other policymakers must accomplish a variety of policy objectives. It is important that laws (1) promote the safety and well-being of abused and at-risk elders while preserving their autonomy and basic rights; (2) support affordable, high quality home and community-based care systems; (3) educate the public and those who work with the elderly on how to recognize the signs that an elder has been abused and how to assist actual and potential victims; and (4) improve civil litigation and criminal prosecution mechanisms and lessen disincentives to initiating such litigation.

It will not be easy to improve existing systems or to forge new solutions. The following research and legislative agenda can serve as a guide for policymakers:

A. DATA COLLECTION

The systems for gathering and reporting data on elder abuse vary from one State to the next. This has resulted in figures that are not comparable between jurisdictions and has impeded the aggregation of reliable statistics at the national level. As a result of the inconsistencies in State-level data collection, Federal policymakers do not currently have the data required to evaluate the need for, and the effectiveness of, allocations for elder abuse. Policymakers should require the State-level use of data gathering and reporting methodologies that will best reveal the national prevalance of elder abuse.

To facilitate future research in the area of elder abuse in all communities, States must also consistently collect ethnic and racial data on the reported victims of elder abuse. This information should be self-reported by the client, and aggregated regularly at State and national levels.

B. RESEARCH

Basic research is needed to test the validity of many popular assumptions about elder abuse and to bridge important gaps in our knowledge.

(1) Research into the characteristics of victims and abusers, and the causes of abuse. Researchers offer many reasons why elders are abused and neglected. In order to design the most appropriate responses we must fully understand each of the underlying causes. Among the research questions which might be asked, is caregiver stress a major cause of abuse and will respite or in-home services provide adequate relief? To what extent do caregivers' personal problems (e.g., mental health problems, substance abuse) cause them to act inappropriately, and should counseling programs be

made more widely available? Are overworked and undertrained nursing home staff lashing out under the pressures of their work, and what staffing levels and training programs will best alleviate these pressures? Is the incidence of elder abuse related to the increase of such societal problems as homelessness, substance abuse and poverty? Resources should be channeled into learning more about issues such as these in order to design programs with maximum impact.

(2) **Research into the benefits and shortcomings of APS programs.** More needs to be known about the benefits and shortcomings of APS programs. Do existing case-finding systems result in too many reports of abuse that are not substantiated and to what extent does this divert resources away from those in greatest need of services? Are APS workers learning about the most serious cases of abuse and neglect, or do these remain hidden in homes, institutions and other settings? Do mandatory reporting laws discourage elders from seeking medical care because they fear that physicians will be required to break the doctor/patient privilege in order to report? When APS authorities substantiate a report of abuse or neglect, are the proffered services appropriate and effective? What kinds of relationships exist between APS agencies and other critical sources of assistance such as legal services providers, law enforcement agencies and long-term care ombudsmen? Are the pressures of limited resources and heavy caseloads causing APS workers to make inappropriate placements?

(3) **Research into alternatives to services traditionally offered by APS programs.** These are available in some locations and it would be helpful to know more about them. How widely available are shelters that serve the special needs of abused elders (e.g., individuals with physical and mental impairments)? Where such shelters are available, to what extent do they empower residents by making them aware of their options and by contributing to a feeling of independence? What has been the impact of counseling programs and other services offered to caregivers and to perpetrators of abuse?

If future research confirms that social isolation contributes to the incidence of abuse, and that counseling programs for caregivers at-risk contribute to the efficacy of service plans for abuse victims, then caregivers and elders subject to the OAA definition of those "in greatest social need" should be targeted first for counseling service.

C. EDUCATION

Education of the elderly, their caregivers and professional providers, and the general public is vital. Just as child abuse prevention groups helped to raise public awareness that parents were abusing their children, and women's groups brought the predicament of battered wives to the public's attention, the public must learn more about elder abuse to lessen its occurrence. Efforts should be made to educate: (1) *elders* about their rights and options; the different planning devices available to permit them to maintain maximum autonomy in the event of incapacity; the importance of keeping a support system of friends and relatives; and

where to seek help if they are abused; (2) *families members* concerning the importance of keeping in close touch with elderly relatives; where to find home and community-based care and respite care services; and how to help elderly members to plan for the possibility of incapacity; (3) *members of the public and professionals who work with the elderly* about the signs that mistreatment may be occurring; indications that an elder is at-risk for being abused, and how to get help for known or suspected victims; (4) *APS workers, advocates, and judges* on alternatives to guardianship and protective orders that are less restrictive of personal autonomy; and (5) *the law enforcement community* regarding appropriate interventions for cases of elder abuse.

D. SERVICE IMPROVEMENTS

Language barriers are consistently cited as an impediment to service for some ethnic minority populations. As this pertains to adult protective service for abused elders, APS programs must support the development of professional staff with the language skills and cross-cultural skills to respond to all elders in their assigned jurisdictions. APS programs might then extend translation services and appropriate cultural training to supporting agencies, including law enforcement and the judicial court system. Some larger metropolitan areas maintain language banks which offer trained translators, although translation by a second party is probably not as effective as direct communication with intervening personnel.

E. OVERSIGHT

In order to improve existing protective and prosecutorial systems, oversight is needed in the following areas:

(1) OBRA 1987, as amended, was a monumental step forward in the ongoing effort to improve the lives of nursing home residents. The law mandated many changes in nursing home policy and procedure that should, if carried out properly, lessen the occurrence of institution-based abuse and neglect. Oversight is critical in order to monitor OBRA's implementation and to determine whether it is having the intended results. Congress should examine whether OBRA's requirements regarding such matters as nurse's aide training and competency, residents' rights, and survey and certification are contributing to an improved quality of life for nursing home residents and a diminished incidence of institution-based abuse and neglect.

(2) Medicaid Fraud Control Units (MCFUs) have made an important contribution through their investigation and prosecution of abuse and neglect cases involving health care facility residents. Unfortunately it is difficult to evaluate their work in a thorough way because the Office of Inspector General (OIG) of HHS, the office with oversight over the MFCUs, does not report data on the results of MFCU proceedings. The OIG should begin to report this data. It would also be valuable to have information regarding the MFCUs' working relationships with other agencies involved in identifying resident abuse cases (e.g., ombudsmen, licensing and certification agencies, legal services) as a way of improving relationships, and evaluating the effectiveness of the MFCUs' work.

(3) Supplemental Security Income (SSI) benefits are reduced when a beneficiary resides with and receives in-kind support from an individual who may be acting as his or her caregiver. The impact of this policy should be examined as it may increase the financial stress experienced by caregivers and contribute to abuse.

(4) Federal representative payee programs have offered beneficiaries limited procedural protections, provided inadequate monitoring of representative payees, and left agencies unaccountable to beneficiaries who were exploited by their representative payees. In response to these problems, the 101st Congress passed legislation designed to protect the rights of beneficiaries participating in the Social Security Administration's representative payee programs. The implementation of this important new law should be given careful attention.

F. FUNDING

Increased funding is needed in the following areas:

(1) The Older Americans Act (OAA) long-term-care ombudsman program provides advocacy for abused and neglected elders residing in institutional settings. A few States have expanded their ombudsman programs into the acute care and home care areas with encouraging results. Additional Federal funding will be required to allow other jurisdictions to expand their ombudsman programs in similar directions. The current funding level barely allows the ombudsmen to carry out their existing responsibilities in long-term care facilities and board and care homes.

(2) With changes continually taking place in State elder abuse legislation and with the proliferation of State and local elder abuse programs, the Nation could benefit from a permanent, federally funded national elder abuse resource and training center. The Administration on Aging (AoA) awarded funds to the American Public Welfare Association (APWA) to establish the National Aging Resource Center on Elder Abuse (NARCEA). However, NARCEA has been a discretionary program under AoA jurisdiction and its funding has recently expired. NARCEA played a central role in the national gathering and dissemination of information on elder abuse. As one of a number of options for the development of a national resource center on elder abuse, Congress should consider granting NARCEA an independent and permanent status with a broadened mandate.

During the 102nd Congress, a number of House and Senate bills have been introduced to provide for the establishment of a national center on elder abuse within the AoA. Among its responsibilities, this center would be mandated to provide for the dissemination of research on the subject of abuse. However, none of the current proposals require the collection or reporting of data on the reported victims of abuse or their caregivers as a condition for the funding of State-level activities. The ready availability and comparability of State data is essential to future research efforts. State funding has been tied to a list of other conditions in these legislative proposals.

Several other potential problems with the bills referenced above include:

- requirements, in most, that States have mandatory reporting laws in place to qualify for funding under these proposals, and
- only two, proposed as amendments to the OAA, are subject to a mandate for the targeting of populations who are at-risk due to social isolation.

Future legislative proposals for a national resource center should incorporate mandates for data collection and reporting. In the development of research priorities, and in the delivery of service if applicable, future proposals should also target populations who are at-risk due to social isolation following precedent set by the OAA. Until the efficacy of mandatory reporting requirements has been demonstrated, mandatory reporting should not be required as a condition for the funding of State-level activities.

(3) Legal representation is needed to protect elder abuse victims and to enable at-risk elders to plan for maximum autonomy in the event of disability. Federal funding for legal services for abused and vulnerable elders is insufficient given the overwhelming need for these services. OAA and Legal Services Corporation efforts to provide representation to such individuals deserve increased monetary support.

G. REFORMING FEDERAL LEGISLATION

There are a number of Federal and Federal/State programs that have an impact on elder abuse. Many of these can be improved in some respect:

(1) There is a pressing need for home and community-based care to relieve the difficulties that unpaid caregivers experience when caring for an impaired elder. Access to these services can help to minimize the pressures of caregiving which may otherwise result in abusive behavior.

Although various Federal entitlements and social services programs currently provide some measure of home and community-based care, much more is needed. In 1990, Congress took an important step in this direction by giving States the opportunity to provide home and community-based care as an optional service under Medicaid.

(2) The Social Services Block Grant (SSBG) program is the major Federal funding source for the States' adult protective services programs. In recent years the States have been forced to distribute a diminishing allotment of SSBG dollars among many different social service constituencies. As a result, fewer States have been using SSBG funds to support adult protective services programs. One way of ensuring greater parity in the way the States allocate their SSBG funds would be to require that a specific percentage of each State's SSBG allotment be used for adult protective services.

(3) Members have introduced House and Senate legislation in the 102nd Congress which would require the States to incorporate procedural safeguards in their guardianship proceedings and to ensure that guardians are trained and accountable to the courts. There has been little action taken on these bills to date. However, it is possible that an aging population and an increasing number of persons living longer with substantial impairments may prompt Con-

gress to move forward on this issue in the future. In light of the numerous documented instances in which proposed wards' rights have been violated, passage of legislation which incorporates these safeguards should be given priority.

(4) The long-term-care ombudsman provisions of the OAA state that the identity of any complainant or nursing home resident will not be disclosed by an ombudsman without that individual's written consent or upon court order. These provisions can conflict with States' mandatory reporting laws, which may require the ombudsman to report an otherwise protected communication. The OAA should be amended to give ombudsmen discretion in reporting abuse where doing so would jeopardize the well-being of a victim. This would avoid placing ombudsmen in the position of violating State reporting laws in order to protect a confidential communication or violating Federal law in order to report abuse.

(5) As currently written, Part G of Title III of the OAA would channel elder abuse prevention moneys into the aging network, which might then create programs that compete with or are superfluous to the States' APS programs. Moreover, when the $2.9 million appropriated for this program for fiscal year 1991 is divided up among the hundreds of area agencies on aging, the amounts allotted are too small to fund meaningful elder abuse prevention activities. If the OAA were amended to give the States broad discretion in the allocation of Part G funds, these potential problems could be avoided.

(6) Federal law provides that MFCUs may review, and, where appropriate, act upon complaints of abuse and neglect of patients in "health care facilities" which receive payments under the State Medicaid plan. This leaves a gap in protection as the States increasingly authorize reimbursement of long-term care provided in home and community-based settings under Medicaid waivers and as an optional service under Medicaid. Laws defining the scope of the MFCUs' authority should be revised accordingly to provide coverage for individuals receiving Medicaid-reimbursed home and community-based care.

(7) When a Medicaid recipient receives a significant damage award in a tort action against an institution, the damage award generally results in termination of Medicaid eligibility. The effect of current Federal law limiting Medicaid eligibility for individuals who are awarded damages in tort actions should be re-evaluated to determine if it is appropriate in all circumstances.

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