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ELDER ABUSE AND VIOLENCE AGAINST MIDLIFE AND OLDER WOMEN

ROUNDTABLE DISCUSSION

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

WASHINGTON, DC

MAY 4, 1994

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ELDER ABUSE AND VIOLENCE AGAINST MIDLIFE AND OLDER WOMEN

WEDNESDAY, MAY 4, 1994

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The roundtable was convened, pursuant to notice, at 1:09 p.m. in room 226, Dirksen Senate Office Building, Ms. Sara C. Aravanis, moderator.

Present: Senator Pryor.

Participants: Sara Aravanis, Lori A. Stiegel, Dr. Rosalie S. Wolf, Handy Brandenburg, Maria Brown, Dr. Terry T. Fulmer, Dr. Toshio Tatara, Pat Reuss, Elma Holder, Tom Carluccio, Joan Kuriansky, and Lou Glasse.

WELCOMING STATEMENT BY LOU GLASSE, PRESIDENT, OLDER WOMEN'S LEAGUE

Ms. GLASSE. Good afternoon. I am Lou Glasse, President of OWL, and I want to welcome all of you here this afternoon, especially the participants at this roundtable. We want to thank you for coming from such long distances to be with us. It is a real pleasure to have you, and I especially want to thank Sara Aravanis for acting as our facilitator at today's roundtable.

As most of you know, OWL is a national membership organization, committed to addressing the concerns of women as they age. Adequacy of income, health care, and housing are essential if women are to be secure in their older years. Security on the streets and in our homes and in our neighborhoods is also essential if women are to have good older years.

It was out of recognition of that, that at our 1993 national convention the OWL membership voted to put this issue on the national agenda. We have been dealing for a number of years with issues of Social Security and pension and health care and caregiving and housing and taking charge of the end of your life; but because violence and the fear of violence has become such a shaper of the lives of midlife and older women, our membership said that it is time to look at this issue, time to address the problem and to see what can be done in our local communities and in our States and at the national level to reduce the incidence of crime against older women.

We know that violence and the fear of violence makes prisoners of many women as they age. They are afraid to leave their homes, to walk out on the streets, to go to the grocery store. We know,

though, that even women in their own homes are oftentimes victims of abuse.

We welcome the opportunity to talk with you and explore with you how severe the problem is and what can be done about these issues. This morning we heard from Senator Biden, Chair of the Senate Judiciary Committee, as he talked about what his committee was proposing to address the problems of violence in our streets, and particularly as it affects midlife and older women. We heard from Senators Pryor and Cohen on their responsibility for aging programs in the Senate, about what could be done to minimize the problem and to address the resources, to address the issue in legislation. And we heard from our good friend, Congresswoman Morella, who has been working on these issues for such a long time and continues to be a strong advocate. We also heard from the daughter of a victim of violence, domestic violence. It was all very, very moving.

But now it is time to hear from you, to talk more about how severe the problem is, and to explore explicitly the call for action that OWL has developed. We want to hear from you about what can be done, how severe the problems are and how the response can be shaped.

In moving to that, let me just say that Senator Pryor will be joining us about 2 o'clock, so I am sure he will want to extend his welcome to you as well. But I want to thank you for your participation and for the audience observance in hearing what is going on.

So, Sara, again, thank you very much.

Ms. ARAVANIS. Joan.

STATEMENT OF JOAN KURIANSKY, EXECUTIVE DIRECTOR, OLDER WOMEN'S LEAGUE

Ms. KURIANSKY. Thank you. I'm Joan Kuriansky. I am Executive Director of the Older Women's League, and I too want to welcome you. I want to thank a few people for having made this happen today.

To begin with, I'd like our Public Policy Director, Dianna Porter, to stand. [Applause.]

Dianna was responsible for coordinating the entire activity, and Irene Jillson, who is sitting over there, helped draft our Mother's Day Report. We thank you very much for giving us the basis on which we can move to our call to action.

The roundtable today was greatly facilitated by the work of two people, Amy Shannon—who has been working with us at OWL, and Anne Riley from the Senate Aging Committee. Thank you, Anne. [Applause.]

There are so many different issues that we want to discuss today. It has been quite a challenge to put them into an organized format and provide an opportunity for real dialogue. We thank Anne and Amy for bringing together such an esteemed group to help us work through this very complex issue. I think if nothing else came out of this morning's press conference, particularly listening to Frances Hicks' story, it was how complex and how many different entities come to bear on making a difference, for older women who face violence in their lives, whether it be the social

service system, the legal system, the medical system or your own family. They all are part of the solution to this challenge.

As we go forward, I also want to thank our funders, who enabled us to hold this roundtable. The Ms. Foundation gave us a grant. They have been historically committed to working against violence against older women and on behalf of women generally. Bell Atlantic, Edison Electric, SEIU, and OWL members and chapters across the country have also contributed to today's event. We have one of our OWL members here who really leads us in our public policy work, and that's the Chair of our Public Policy Committee, Gretel Weiss. [Applause.]

So, OWL has developed the "Call to Action," which most of you have seen. I want to highlight seven areas that we have identified as areas that we want further discussion on today and action later by policymakers, the community, and women themselves. Those areas include:

Research and data collection.—We are so often stymied by the lack of information. Each of us know in our own lives what the experiences are that we face, but unfortunately until it is turned into facts and figures, often policymakers aren't willing to take action. We often tend to lose the trends and patterns without that kind of data collection. So uppermost in our recommendations is that data be collected by age and gender, as well as race, and in increments of 10 years. The Older Women's League, which has prided itself historically on being able to provide data-rich information, was overwhelmed by the paucity of data that we had to work from in this particular issue.

Reporting.—How do we document this issue? How do we help women help themselves? Is reporting the answer? We don't know; we think there needs to be a lot of discussion on that. We hope that today will lead us to some kind of resolution of that matter.

Policy reform and implementation.—Some of the policy issues which the Call to Action addresses are the Violence Against Women Act and national health reform. We want to see a health system put in place that includes long-term care, with support for caregivers; domestic violence screening and prevention services, we believe that the Older Americans Act can better respond to women who are abused, whether they be at home or in institutions. In looking at the Hate Crimes Act, can we realize age is not included and should be? These are just some of the policy reform recommendations that we make in our call to action.

Preventive measures.—How do we assure that there is adequate funding for abuse prevention and ombudsman programs for public education? How do we effectively educate our providers and our law enforcement personnel who come into contact with battered, neglected, and abused women every day? What can we do as a country to provide a standard of public education that challenges the negative, demeaning stereotypes of both women and the elderly. It is these stereotypes which so often lead to the kind of ignoring of problems that we see over and over again.

And importantly, what can we do to empower women so that they can safely take action on their own behalf? What are the tools that we have to develop or make more available so that women do have the ability to live free of violence?

These are difficult questions. We have among you today experts who have the ability to begin to try to answer these questions, you come from very different perspectives, with much to be learned from the battered women's movement and the aging network. The Aging Network has historically dealt with elder abuse, whether adopting "safe corridor" or ombudsmen programs. Can these programs be expanded to include women who face abuse, regardless of her age? Can applying the empowerment model, implicit in the provision of hotlines and shelter services for battered women, primarily younger women, be made accessible to older women? How can we best bring together the expertise each of you have developed and build on each other's successes. At the same time I encourage us to look at some of the underlying differences and commonalities effected in the different perspectives offered here today.

While we could talk a long time about the difference between the battered women's movement and aging network, we must remember that for the woman who is experiencing the abuse, it doesn't quite matter what the philosophy is that underlies the availability of services to help her. In fact, there is a great commonality of interest when you look at the profile of an abused older woman. She is one who is victimized by the unequal balance of power in the society; a woman who is often isolated; who has no longer the association with friends or family to help her out of a situation; she can be a woman who may have tried to get out but did not find support from the social service, legal, or medical communities. Whether she is 20 years old with three children, or 70 years old, these are defining characteristics that we want to address in this discussion.

I hope we will build on the work that you've done in your own fields and on OWL's "Call to Action." We intend to bring this level of expertise to bear on Congress. We are delighted that we have a Congressional roundtable to bear witness to this discussion. The findings will be translated into black and white. We believe they will be useful to Congress as it continues to work on these issues.

So again, welcome. Let me also thank Sara for being willing to moderate. Sara comes to us from the National Association of State Units of Aging who has worked closely with OWL on many issues, Sara is also an expert in this field. We would hope that you will not only be the moderator, but will share some of your expertise with us as well.

Thank you.

[OWL's 1994 Mother's Day Report follows:]

OLDER WOMEN'S LEAGUE

1994 Mother's Day Report

A Mother's Day Call To Action:

Ending Violence Against Midlife And Older Women

A Message From Lou Glasse

President of the Older Women's League

Happy Mother's Day! As you celebrate this holiday, be grateful if the women in your life have been unaffected by violent crime and elder abuse. If so, they are among the lucky few.

Anyone who talks to older women throughout this country knows that violence and fear of violence—from a stranger, a family member, or a caregiver—are powerful forces that shape their lives. Sadly, the rising tide of violence in America is harming the quality of life for many midlife and older women, who too often are ignored by the policymakers who are working to address this epidemic. The statistics are sobering:

- More than a million older American women are victims of violence each year.
- Twice as many women over age 65 are mugged at or near their homes than younger women, and three in four of these incidents occur during daylight.
- One of every hundred women age 50 to 64 is likely to be a victim of a violent crime, and two of every hundred women age 65 or older is likely to be a victim of theft.

Fear of crime causes countless midlife and older women to severely limit their activities and restrict their daily lives. This costs society the valuable contributions they could make through providing child care, social contacts and assistance to friends, relatives and other members of their communities, volunteering, advocacy, and active participation in their religious communities.

But if women are staying home to stay safe, they are not necessarily achieving their goal. Home, too, can be a dangerous place.

- Last year, more than 700,000 midlife women (age 45 to 65) were physically abused by their spouses.
- Nearly 400,000 older women living in institutions are victims of physical or sexual abuse.
- In 1991, 40 percent of violent crimes against midlife women (age 50 to 64), and 18 percent of violent crimes committed against older women (age 65 or over) were committed by family members, friends or acquaintances.

Far too little energy and resources have gone into understanding and addressing how violent crime, elder abuse, and fear of assault shape the lives of this nation's midlife and older women. This lack of acknowledgement and understanding results, in part, from the fact that there is shamefully little data collection on elder abuse. Furthermore, few breakdowns of violent crime identify the age, gender and race of victims. It is long past time that police departments and state and federal agencies gather the data that will shed light on these problems.

The public face of violence in this country may be a gang of young people armed with automatic weapons who shoot indiscriminately into crowds or terrorize innocent passers-by. But the real victims include the women in their 50s struggling to regain their sense of security after an assault, the women in their 60s too terrified to leave their homes, and the women in their 70s and beyond who rely on caregivers who sometimes become physically or sexually abusive.

Far too many American women are living out their final years so frightened of assault that they become virtual prisoners in their own homes. It is time for our society to establish that every older woman has the right to dignity, security, and freedom from fear.

This Mother's Day and every day, midlife and older women deserve tc live without fear. It's time to address the shameful fact that too many midlife and older women in this country face violence and abuse every day.

With this report, the Older Women's League issues a multi-faceted Call To Action that includes steps that citizens, policymakers, and elected officials can take to control and reduce the rising tide of violent crime. We must act now to address this epidemic. There simply is no time to waste.

666 11th Street NW, Suite 700 • Washington, DC 20001

Older Women In Jeopardy

A 75-year-old woman from Washington state lived by herself in an old, dilapidated home. A neighbor reported that the woman's youngest daughter was financially exploiting the mother, having her sign blank checks and than proceeding to drain her bank accounts. The daughter also removed many items of furniture from the family home. The older woman appeared confused and disoriented, and was suffering from short-term memory loss. There was no food in the home and the heat had been turned off when a caseworker visited. The older woman had come to the neighbor on several occasions to beg for food.

A 90-year-old widow in California ordered $113 worth of shoes from a company soliciting orders through the mail. She never received the shoes nor a refund.

A woman in Wisconsin, living on a $640 monthly Social Security check, wrote checks for $600 and $1,200 to buy vitamins, after a company told her the purchases would allow her to win a car.

A 79-year-old Wisconsin woman was physically and psychologically abused by her husband of 42 years. Although her husband had always been a controlling man who had threatened and emotionally abused her throughout their relationship, the physical abuse did not begin until her debilitating stroke 6 years previously. Besides being battered by her spouse, she is also being denied assistance in self-care tasks. To punish her, her husband ignores her pleas for help.

A 78-year-old woman in Kansas suffered a stroke. Once home, she advised her guardian that her assistance was not needed. After several attempts were made to have her placed in a nursing home, the sheriff, a nursing home administrator, and a nurse delivered a court order requiring her to enter a nursing home immediately. The woman was not informed there was to be a competency hearing, she was not present at the hearing and she was not represented by a lawyer of her choosing. She spent five weeks in the nursing home and was released after contacting and working with the state office on aging and an ombudsman.

An 82-year-old Arkansas woman, illiterate and mentally ill, owned her own farm. An ex-farmhand showed up at her door and got legal guardianship of her person and estate. The elderly woman was not allowed to go anywhere without permission and was given no money. She was forced to live in a small trailer with no water, heat or bathroom. She reports being physically and sexually abused by the guardian.

U.S. House of Representatives Select Committee on Aging
and Senate Special Committee on Aging

A Blueprint To Address Violence Affecting Midlife And Older Women In America Today

The Older Women's League (OWL) calls upon *elected officials* to articulate a national policy and lead a national effort to turn our communities around and eradicate all forms of violence in our society, including those experienced by midlife and older women. OWL urges *community leaders* to initiate innovative prevention and intervention programs to make life safer and more secure for midlife and older women. And OWL calls upon *American women and men* to address all forms of violence through education and empowerment of themselves, family, friends and neighbors, and others.

Research and Data Collection

- **Existing resources for the collection of data on violence and other abuse should, at a minimum, disaggregate by race, gender, and age breakdowns in 10 year increments.**
  - The types of abuse reported through the National Center on Elder Abuse (NCEA)—physical abuse, sexual abuse, emotional or psychological abuse, financial or material exploitation, and neglect—must be disaggregated by gender. At this time, few of the statistics reported by the states to NCEA identify whether the victim is male or female.
  - Reports of victimization by the Bureau of Justice Statistics National Crime Victimization Survey present minimal data disaggregated by gender, age, and race. Reports should be disaggregated by these variables.
  - It is imperative to know who is vulnerable in order that the federal government, states and communities can take appropriate action.
- **Congress and the Clinton Administration should mandate research on all forms of violence and other abuse against midlife and older women.**
  - Research is urgently needed on: domestic violence; elder abuse, physical, mental, and financial; street violence; sexual harassment in the workplace; incest and rape; institutional violence; and fraudulent acts that target older people.
  - Questions to be addressed include:

    What is the incidence and prevalence of these problems?

    Are there significant differences between older and younger battered women—for instance, situations giving rise to abuse, risk of serious bodily harm, options available to escape the dangerous situation, and service and treatment availability?

    What are the risk factors?

    What are the barriers that prevent older women from seeking and receiving help?

    What role do ethnicity and race play in the way violence is perceived and services are sought?

Reporting

- **Congress should appropriate funds to examine whether the elder abuse provisions of the Older Americans Act should mandate state reporting of elder abuse. Where states currently mandate reports, they should be required to report incidents of elder abuse to the federal government. Social service and health care personnel should be required to report these incidents to their states.**
  - Currently, some states report incidents of elder abuse to the NCEA under a voluntary national system that is funded by the federal Administration on Aging (AoA)—but many states do not collect or report data on elder abuse.
  - Among states that do collect data on elder abuse, definitions differ significantly. Uniform definitions should be adopted by AoA and utilized by every state.

Policy Reform And Implementation

- **The Violence Against Women Act (VAWA) should be swiftly implemented and vigorously enforced, as should other provisions in the anti-crime bill.**
  - The VAWA establishes federal penalties for sex offenders and spouse abusers, and civil rights protections for victims of gender-based assaults. Other provisions in the Senate anti-crime bill establish guidelines that will create "sufficiently stringent" penalties for crimes against older persons, and more severe penalties for telemarketing fraud targeting older persons. No further time should be wasted in making these bills the law of the land.
  - The federal government should distribute funds to states as quickly as possible so states can immediately expand and strengthen services and programs for victims, train law enforcement officers to more effectively identify and respond to violent crimes against women, support counseling services, and protect older people from abuse by care providers.
  - States, in turn, should direct grant applicants to specify that they will include a focus on midlife and older women in their programs.
- **Age should be included among the protected categories identified in all state and federal "hate crime" legislation.**
  - Hate crimes are violent incidents in which the perpetrator selects a victim because of a specific attribute or

characteristic. The anti-crime bill increases sentences when a victim has been selected because of race, color, religion, national origin, ethnicity, gender, disability, or sexual orientation. Age should be added.

- **Congress should quickly pass and vigorously oversee implementation of the *Violence Reduction Training Act*, which trains health care providers to identify and refer victims of domestic violence and sexual assault.**
  - In addition to appropriating funds for domestic violence, funds also should be appropriated for elder abuse.
- **A coordinating commission on violence comprised of the Attorney General, Secretaries of the Departments of Health and Human Services, Labor, Housing and Urban Development, other Cabinet departments, the Director of the National Institutes of Health, and the Chairman of the Equal Employment Opportunity Commission should be established.**
  - Violence cannot be dealt with in isolation. A holistic approach will be more effective in addressing the rising tide of violence in American society. Partnerships among agencies at all levels must be formed to facilitate reporting, enforcement, preventive and intervention measures, training, and long-range planning.
- **The Department of Housing and Urban Development should give priority to older abused women who seek public housing slots.**
  - Women often remain in abusive situations because they do not have an alternative place to live. Public housing agencies should reserve emergency slots for women who qualify and whose safety is at risk.
- **The health care reform legislation ultimately passed by Congress and signed by President Clinton must incorporate training, treatment and prevention strategies to address violence.**
  - Violence is a public health issue. Health care reform cannot be considered comprehensive unless it addresses violence. The new health care plan should explore and support creative efforts to address violence such as multi-disciplinary training in order that health, social services and other professionals have an understanding of each other's roles and capacities; assessment guidelines for health and social service professionals and para-professionals; and public and private partnerships to prevent and combat violence.
  - Health care reform must address the need for respite care, because home and community-based long-term care services can alleviate stress among family caregivers and allow them to continue caring for their family members. Lack of respite care takes a huge toll on the physical and emotional well-being of caregivers and creates situations that can lead to abuse.
  - The needs of those who provide the respite care in the home and community as well as in institutions—the long-term care workers—must be considered in health care reform. Adequate training, wages, working conditions, and benefits for them will ensure high quality and standards of care in these settings.
- **Congress should mandate increased coordination between the federal government and the states in enforcing federal consumer protection laws, and more comprehensive public education on consumer fraud.**
  - Both federal and state law enforcement entities have limited resources available to combat consumer fraud. States must be empowered, not restricted, in their efforts to enforce federal consumer protection laws. In addition, multi-state efforts are an effective and cost-efficient means of apprehending perpetrators of fraud who move from state to state.

Preventative Measures

- **The 1992 recommendations of the Senate Special Committee on Aging to improve federal and federal/state programs which have an impact on elder abuse should be instituted immediately:**
  - State and local agencies should make home and community-based care more readily available to unpaid family caregivers, many of whom struggle to care for impaired elders.
  - Congress should quickly pass legislation requiring states to incorporate procedural safeguards in guardianship proceedings and to ensure that guardians are trained and accountable to the courts.
  - Congress should revise the laws that define the scope of authority of Medicaid Fraud Control Units to provide protection not currently authorized for individuals receiving Medicaid-reimbursed home and community-based care.
- **Federal policymakers should provide adequate funding for existing federal programs that address violence and abuse against midlife and older women.**
  - The Older Americans Act of 1992 consolidated elder abuse prevention and ombudsman programs into Title VII, Vulnerable Elder Rights Protection Activities. However, Congress has provided no funds for Chapter 4, state elder rights and legal assistance development programs. Funds under Title VII should be earmarked for Chapter 4 and for social service programs that help abused elders.
  - The OAA of 1992 also authorized two studies by the Institute of Medicine (IOM) focussing on quality—home care quality and quality of care provided in board and care facilities. Recipients of long-term care services are

too frequently victims of those purporting to be care providers. Funding must be appropriated for these studies.

- Shelter programs must provide midlife and older women with the opportunity to participate in employment and training programs in order that they may secure financial independence through employment.
- A specific percentage of each state's Social Services Block Grant (SSBG) allotment should be used for adult protective services, to help ensure parity in state allocation of SSBG funds.
- Part of funds allocated to eradicate domestic violence under the Domestic Violence Prevention Act should be earmarked to address the concerns of midlife and older women.

Education And Training

- **Americans must be educated and trained to examine the underlying power issues that prompt abusive behavior.**
  - Violence is closely intertwined with an individual's need to exert control over another's life or exploit another's vulnerability. It is imperative that the root causes of violence are understood and addressed.
- **Practicing physicians, medical students, and other health professionals should be trained to implement American Medical Association guidelines for assessing domestic violence. Similar protocols must be instituted for assessing elder abuse.**
  - Congress should enact the Domestic Violence Identification and Referral Act—introduced in both the House of Representatives and the Senate—which requires domestic violence training in medical, nursing, and other health profession schools. Elder abuse should be included in the definition of domestic violence in the Senate bill.
- **Services must be coordinated at the state and local levels among the medical, social service, aging, law enforcement, and judicial networks.**
  - Social service providers should establish cooperative relationships with medical schools in order to provide training for medical students and to improve medical services and referrals for older clients.
  - Personnel in the Older Americans Act network and adult protective services should coordinate training and services in order to concentrate more funding on services and assure that adequate resources are available to address the needs of midlife and older women.
  - Senior centers and other community service programs should assure that counselors are available, wherever midlife and older women congregate, who are sensitive to the possibility that there might be violence in their past or present.
- **Existing materials should be more widely distributed and new materials developed to help service providers who work with midlife and older women.**
  - Materials developed for nursing home administrators and staff by the Coalition of Advocates for the Rights of the Infirm Elderly, for instance, which can help explain and minimize conflicts between staff and residents should be much more widely available.
- **Police officers must have adequate training in implementing arrest laws, responding to calls for help and enforcing court orders. Prosecuting attorneys and judges also should receive training on issues and procedures to be followed in domestic violence cases.**
  - In one study, 60 percent of women reported acts of abuse by their abuser after going to court. Enforcement must continue beyond the initial arrest.
- **Police departments and bank personnel should be trained to increase their awareness of financial fraud committed against older women.**
  - Bank personnel should also encourage older women to arrange the direct deposit of their Social Security checks to prevent theft and/or injury.
- **Judges should have continuing training on domestic violence and elder abuse cases.**
  - In Baltimore, Maryland, all new judges of the district court are sent by the chief administrative judge to a local domestic violence project to receive a one-day orientation and training session on domestic violence issues and procedures.
- **State and local long-term care ombudsmen and adult protective services personnel should be adequately trained to help them assess abusive situations and provide assistance.**
- **Caregivers should have education and training to cope with the stresses of caring for the physical, emotional, and social needs of the person for whom they care.**

- **The Department of Labor should develop curricula and training modules on sexual harassment prevention and require training in the workplace.**
- **Employers need to expand employee assistance programs (EAPs) so that they address violence in the lives of employees.**
- **Apprenticeship training programs also should include a module on sexual harassment laws, prevention, and redress.**
  - Unions should address sexual harassment in the workplace by requiring that their contracts contain language specifically prohibiting sexual harassment and declaring that acts of sexual harassment violate the contract.
- **Public education initiatives to prevent violence against midlife and older women must be adequately funded.**
  - The Administration on Aging's initiative on older women should fund public education and outreach efforts regarding violence.
  - Municipal police departments and state and local attorney general offices should earmark funds for such public education.

Empowerment

- **Individuals, associations, organizations and public agencies should initiate programs to ensure that midlife and older women can take control of their lives.**
  - State and local domestic violence coalitions should be strengthened and must include a focus on the needs of midlife and older women.
  - State violence hotlines should address the needs of midlife and older women who find themselves in perilous situations.
  - Domestic violence shelters should train staff to work with midlife and older women, conduct outreach to this population, and offer special programs and services designed to meet older women's needs.
  - Social service agencies and women's groups should establish support groups for older women—in some cases, telephone "meetings" for older women when they cannot leave their home or institution.
  - Municipalities should institute a "Safe Corridors" program, modeled on a New York City initiative in which the Department of Aging worked in cooperation with the police department to increase police presence at least one day a week in ten shopping areas so that older persons could feel safer living, strolling, shopping, and running errands.
  - Hospitals should set up elder abuse projects designed to ensure early detection, screening and intervention of elder abuse. There must also be adequate follow-through by police and social services providers after hospital discharge.
  - Schools and community colleges, employers, community agencies, and senior centers all should offer empowerment seminars for women of all ages that include education about warnings signals in relationships and alternatives to remaining in a dangerous, abusive situation.
  - Police departments should provide older persons with information on how to protect themselves from fraudulent schemes and to make the right decisions by checking out companies and individuals before doing business with them.
  - Communities should facilitate much more advocacy to ensure the security and welfare of older women.

Legal And Judicial Reform

- **Judiciary systems should encourage courts to specialize in domestic violence and elder abuse cases.**
  - Judges should be designated to develop expertise in domestic violence, which can result in victims receiving more referrals to shelters and community organizations. These judges can impress upon abusers the seriousness of their behavior and impose stemer sentences. Pennsylvania, Illinois and Colorado already have such courts.
  - Prosecutors in large offices should designate special prosecutors to develop expertise on domestic and other violence against women cases.
  - Prosecutors should designate specialized fraud teams to track and prosecute perpetrators of scams.
  - Courts should facilitate the tracking of elder abuse cases and avoid issuing conflicting orders, such as when conflicts arise between criminal and civil proceedings with regard to elder abuse issues, including guardianships.

ABOUT THE OLDER WOMEN'S LEAGUE

This 1994 Mother's Day Report by the Older Women's League is the ninth in a series begun eight years ago. This year "A Mother's Day Call To Action" issues recommendations for ending violence against midlife and older women.

Making these invisible problems visible was the primary goal of the Older Women's League when it was founded in 1980. OWL is a nonprofit, membership organization—the first national organization to focus solely on midlife and older women's concerns. It strives to achieve economic and social equity for midlife and older women, to improve their image and status, and to provide mutual support for its members. In just 14 years, OWL has become firmly established as a national voice for older women—a segment of the population that has long been unrepresented.

OWL was conceived by two California women, Tish Sommers and Laurie Shields, whose earlier work to eradicate the job inequities midlife and older women face helped to create the displaced homemakers movement. Although Sommers died in 1985 and Shields in 1989, their legacy continues in the more than 100 OWL chapters throughout the United States. Under their leadership, OWL formed a coalition called Citizen's Council on Earnings Sharing to monitor legislative action and encourage future steps toward Social Security reform. OWL was also instrumental in passing significant pension reforms in 1984, 1986, and 1988 to help increase the number of women covered. In 1991, OWL took the lead in forming the Campaign for Women's Health, a broad coalition of women's groups, unions, and health care organizations, working to achieve a health care system sensitive to the needs of women of all ages, races, income and personal life styles. In 1992, OWL participated in a Congressional study group on women's retirement income which developed recommendations for Social Security and pension reform.

OWL's national agenda, set by its members, consists of educational and advocacy issues in addition to eradicating violence against midlife and older women: Social Security reform, pension rights, job discrimination, universal access to health care, family caregivers, federal budget priorities, staying in control to the end of life, and housing. Education takes many forms: consumer reports and pamphlets, the OWL OBSERVER newsletter, testimony before legislatures, media outreach, the Gray Paper series, the OWL Powerline, and conferences and leadership training. OWL's leaders come mostly from local chapters, whose members work on the national agenda, on state and local concerns, and on bringing women together for mutual support.

OWL's motto is "Don't agonize—organize!" You are invited to join OWL to show that you are willing to work toward brighter futures for all women.

ACKNOWLEDGEMENTS:

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STATEMENT OF SARA C. ARAVANIS, MODERATOR, INSTITUTE DIRECTOR, NATIONAL ASSOCIATION OF STATE UNITS ON AGING

Ms. ARAVANIS. Thank you, Joan and Lou, and it is my pleasure to be here with you today. I am going to establish the rules for what we do today, but first before I do that I want all of you people in the audience to know that we have here with us today experts—experts in the field of domestic violence, elder abuse, adult protective services, law enforcement, justice, legal assistance, and advocacy. We have here a very important core group of people who can help move an advocacy agenda on behalf of midlife and older women. In the arena of violence, that is very important; and it's just so exciting to play a part in this.

I think most of you know that the purpose of this session today is to make sure that we have an open dialogue and discussion among all of these experts; that we identify common concerns, and that we actually use this time to promote linkages among all these different programs services and experts that we have assembled here. But, we also use the time to ask each other questions and to share ideas about things that we think are good ideas that are happening in communities. We need to identify gaps that we see in community services, as well as gaps that we see in national and State policy.

We have listeners here. We have listeners from the Aging Committee, as was pointed out, and from OWL; and we want the audience to be participatory listeners in that you certainly may feel free to ask questions of the panel. We want to encourage your full involvement in this, as well. It will be part of my job to make sure that you have that time.

What will be the outcome of this session? All of you can't always appreciate the benefit of having written comments, written testimony from all of these experts on a particular issue. The Committee is going to do a major committee print of all of this day, focused on violence related to midlife and older women, so we will have a record. The Committee also wants these proceedings to contribute to an action agenda that they can work on related to appropriations and authorizations. The Committee wants to identify some policy issues and program ideas to actually pursue, and certainly, that goes for OWL as well. OWL is looking for more empowerment strategies and looking for recommendations that we can work on together.

I am going to ask each of our participants around the table to introduce themselves, although I'm going to give you just a little bit of my personal introduction of them. But I will ask them to introduce themselves, and just after they introduce themselves, take a couple of minutes—and I mean a couple of minutes—to speak to one of the owl recommendations that he or she feels very strongly about. In this way we can put on the table your priority recommendation and how you feel about it; whether or not you feel positive about it; or if you feel that there are some areas that need to be enhanced.

Then, I will go around the table with a series of questions that OWL asked me to involve you in discussing and we will spend some time on those questions.

As you are responding to those, I ask you to be rather succinct, to keep your comments focused, and if you can, support and build on each other's comments so that we can get a sense of consensus. However, we do want different points of view as well; so if you don't agree with the majority recommendation, the floor is certainly open to you as well.

Remember, though, we are not actually trying to reach consensus here. We want the listeners, and all participants, to be aware of controversy, to be aware of the various issues and various points of view. But we also want to identify common ground, and certainly common ground in the area of prevention, empowerment, and good practices.

I'm going to make sure that we give everybody a chance, and I am going to make sure we give the audience an opportunity to ask questions if you want. Then we will attempt to summarize the discussion at the end.

[The prepared statement of Ms. Aravanis follows:]

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NASUA

A Mother's Day Call to Action: Ending Violence Against Midlife and Older Women

Submitted By

National Association of State Units on Aging

Sara C. Aravanis

Associate Director for Elder Rights

The National Association of State Units on Aging is pleased to be a participant in these roundtable discussions. We applaud the Committee and the efforts of the Older Women's League in calling national attention to the pervasive problem of violence in our communities. Too often, older persons, and particularly older women are not included in the long list of victims who have ready access to services and intervention by the justice and social supports systems. This national Mothers Day effort will help all of us who are concerned with promoting and protecting the rights of older persons.

The following are the comments of the National Association of State Units on Aging relative to the recommendations of the OWL's Mother's Day Report.

- Increased research and data collection. We agree with the intent of this recommendation however, we suggest that sufficient data collection requirements exist at the federal, state and local levels but the problem remains: we have difficulty aggregating data from various sources which makes it very difficult to identify trends, and priority needs. We suggest that the Committee work to include within the anti crime bill incentives for governors to establish violence information and data task forces which might analyze existing data and identify gaps in the violence data base. Further, a similar effort should be conducted at the federal level.

  With regard to national research and crime statistics, we think it is absolutely essential to include older persons/impact on older persons in various crime related studies; and to assure that we have the ability to disaggregate critical crime data by race, gender and age. This approach to data collection and analysis should also include violence and crime incidents in nursing homes and other long term care facilities.

- Reporting. We do not agree that scarce research funds should be expended to examine whether the elder abuse provisions under the Older American Act should mandate state reporting of elder abuse. The parameters of reporting or victim identification laws should remain a responsibility of the state. In fact, all states currently have procedures to receive and act on reports of abuse. Mandated reporting is the approach in 45 jurisdictions; in 8 states the approach is voluntary. Mandated reporting parallels too closely the child abuse model which is not appropriate for an adult service system.

- Policy Reform and Implementation. We agree and fully support the recommendations in this part. We would encourage the Committee to influence the development of guidelines under the anti-crime bill. the VAWA and other avenues to assure that older persons who suffer losses including "small loses" i.e., loss of eye glasses, dentures, small amounts of money and, that no matter where they live -- in nursing homes, board and care, or individual residences -- older women are guaranteed full protection of the law and adequate assistance to recoup the item or value of the items involved.

Secondly, we fully support the strengthening of victims services, training for law enforcement and other counseling services. However, we believe there must be requirements within the implementation guidelines requiring that special attention be devoted to serving the needs of older victims.

It is our experience that the women's violence network does not have the expertise to serve and older population and that collaborative efforts with the aging/elder abuse network will be needed to adequately serve older women who are victims of violence.

- "Hate Crime" issues. We support the inclusion of age among the protected categories in the anti-crime bill's sentencing enhancement provisions.

- Violence Reduction Training Act. We support the intent of OWL's recommendation that older victims receive the benefits of funding in this arena. If special funds are not designated for elder abuse, we urge that grantees be required to assure that they will serve older victims in accordance with their needs.

- We wholeheartedly support the recommendations calling for a federal level coordination commission. We suggest that funding or other incentives be provided to states which will enable governors to establish or support similar commissions.

- Home and Community Based Long Term Care Services. We applaud OWL for their insight in making the very important connection between the prevention of family violence/elder abuse and the availability of home and community based services. We support the call for a comprehensive approach for home and community based services and pledge to work with OWL and others to assure that health care reform at the federal and state levels includes this approach to choice and justice for older Americans.

- Coordination of Federal and State Consumer Protection Laws. We support OWL's recommendation and recognition of the critical role played by consumer protection entities in the prevention of elder abuse, particularly in cases involving financial exploitation.

- Preventative Measures. We support the recommendations concerning home and community-based care, guardianship safeguards, and Medicaid Fraud Control Units. We would suggest that the Older Americans Act, as currently authorized, by calling for the development of information sharing policies, and by encouraging the development of memoranda of understanding between adult protective services and the long term care ombudsman program, provides appropriate safeguards to assure that victims are not jeopardized by state reporting laws.

- Title VII of the Older Americans Act. We welcome OWL's support for an appropriation for a critical but unfunded chapter of the OAA - State Elder Rights and Legal Assistance Development Programs. Under the authority of this section, states are encouraged to develop an analysis of the "state of the state" vis a vis threats to self determination and the exercise of individual rights. Funding for this chapter is critical for assuring a comprehensive approach to elder rights under the Older Americans Act and we hope the Committee will assist us in obtaining funding for this chapter of the Act.

- Social Service Block Grant (SSBG) and Domestic Violence Funding. We believe the recommendation to earmark portions of the SSBG are well intentioned and, indeed, would go far to assure that funds to support the delivery of adult services in the states, are available at a level approaching equity with child abuse and other services. However, we do not favor a federal mandate for earmarking or set-asides under SSBG. Rather, we encourage OWL and other advocates to be active at the state level in demonstrating the needs of adults and older persons for services provided under SSBG, especially adult protective services, and mobilizing support for adequate funding in this arena.

  Regarding funds under the Domestic Violence Prevention Act, again, we do not favor earmarked funds for elder abuse. Rather, we would encourage the Committee to work for the adoption of intent language or otherwise require HHS through its regulation and grant making process to assure that older victims of domestic violence have access to and are served by these systems; and that appropriate interventions would be designed and delivered in coordination with the elder abuse and adult protective services systems.

- Training of Physicians and Other Health Care Professionals. We are very pleased that the American Medical Association has recently published Guidelines for Assessing Elder Abuse. The National Association of State Units on Aging played an active role, assisting in the development of these guidelines. We look forward to working with OWL to encourage the use of these materials. We also hope that the Committee will identify several mechanisms to promote training for health professionals on elder abuse through such entities as Geriatric Education Centers and other continuing education vehicles. State Units on Aging and AAAs by and large, have not had success in reaching these professionals with training. Continuing emphasis is needed.

- Coordination. The recommendations concerning coordination - with medical schools, and among elder abuse and adult protective services professionals and long term care ombudsmen - is exactly what is needed at the state and community level. We encourage the Committee's active assistance in helping to foster greater cooperation between these critical but distinct service systems. The recommendation to devote particular training attention to law enforcement, attorneys, judges, financial institutions is also encouraging. These are the key actors who must work together in serving victims and in the prevention of elder abuse.

- Caregiver and Public Education - we support and encourage the adoption of the OWL recommendations concerning caregivers. We urge the Committee and others concerned with this issue will consider expanding the coverage of those recommendations to address "care givers" in nursing homes and other long term care facilities, as well. Hands-on providers in every venue need training and support to adopt the coping skills necessary to prevent abuse and violence.

- Empowerment. The recommendations in this section are fully supported and we hope this Committee will work closely with congressional colleagues to see that these are implemented. These recommendations promote attention to the needs of older victims within the fabric of the domestic violence system. We feel that the outcome of this approach will reap significant benefits for older victims.

- Legal and Judicial Reform. We support the recommendations in this arena and would also call the Committee's attention to the efforts of the ABA Commission of Legal Problems of the Elderly to advocate for the development of "family courts" throughout the nation. We think this approach could go far in assuring that judges, attorneys and other linked systems deal with violence and abuse in a holistic manner.

The National Association of State Units on Aging has great respect for the work the OWL is doing on behalf of older women. Likewise, this Committee and your dedicated staff are to be congratulated for holding this symposium today. We look forward to assisting both the Committee and OWL in pursuing these recommendations which will have a significant impact on the prevention of violence in our communities, within families, and in care providing facilities.

Ms. ARAVANIS. Let me proceed to open this session by introducing someone who has become a very good friend of mine in this arena of elder abuse. His name is Tom Carluccio. Tom is the Director of the Medicaid Fraud Control Unit in the State of Delaware. He works for the Office of the Attorney General there, and he has also been an officer—actually, President—of the National Medicaid Fraud Control Unit Association.

Tom is a very, very sensitive person. He has worked very hard on a lot of elder abuse cases in his State, cases that people thought were hopeless; he has come along and helped bring the full pressure of the justice system to the benefit of older people in these cases.

I would like to introduce Tom. Tom if you would speak to an issue that you feel strongly about?

STATEMENT OF TOM CARLUCCIO, ESQ., DIRECTOR, MEDICAID FRAUD CONTROL UNIT, OFFICE OF THE ATTORNEY GENERAL, WILMINGTON, DE

Mr. CARLUCCIO. I would first like to thank the Older Women's League for my invitation here to participate in this very important discussion. This is an area that needs a lot of work, a lot of help—political—from us, from the public, from everyone in order to make life better for older women.

As was said, I'm the Director of the Medicaid Fraud Control Unit and the Past President of the National Association of Medicaid Fraud Control Units. What is a Medicaid Fraud Control Unit? Well, we do provider fraud on the one hand, and on the other hand we do elder abuse and neglect statewide, so we handle all the elder abuse and neglect in facilities. Medicaid Fraud Control Units are in 41 States right now and we're going to be in all the States by 1995.

The contribution that we make is that we are oftentimes the only policeman on the block for elder abuse prosecutions in each State, since local police agencies and local district attorneys do not have the resources or the expertise to prosecute these cases. So we seem to be the only person that the elder community can turn to.

Also, Delaware was the first State to get a conviction, with respect to its emotional abuse statutes. In our State if you emotionally abuse an infirm adult, it is a crime. We had the first jury conviction, which was upheld by the Delaware Supreme Court.

As far as addressing the issues, of course I'm going to address legal and judicial reform. All States need better laws to protect victims of elder abuse and domestic violence. Since victims cannot tell us many times exactly what harm they are suffering, we need laws to prosecute the act rather than the actual harm. So if somebody is punched and it is an assault, how can we tell who did the crime if they cannot respond and if there is actual harm? Under Delaware abuse law and the adult protective law, it is the act of the punch that is the crime, and the intent of the person to harm and not the harm to the victim. Without those laws, we wouldn't be able to prosecute half the cases we receive.

Also, under legal and judicial reform, we specifically want judges and prosecutors trained and specifically assigned to deal with domestic violence, and also with elder abuse cases. It seems at this

point in time, if I don't go in front of a jury, my chances of winning are very poor. Juries have compassion for the cases and see the evidence a lot clearer than most of the judges. I get arguments from the legal community more than I do from juries that convict these people who abuse the elderly.

So the more training and the more assignments a judge gets to these areas, the more understanding they will have, so that at sentencing the defendant will get the appropriate sentence.

Also, the coordination of State and Federal agencies under legal and judicial reform—I have lost cases because of the lack of coordination between adult protective services, the long-term care ombudsman, and all the agencies. It seems that not everybody is trained to investigate, and everybody is giving caretakers different opinions of what the law is. Therefore, I think there is a uniform law that needs to be passed as far as definitions of abuse and neglect are concerned; that would help everyone understand the crime of elder abuse.

An example that I have that was a horror story was when I went to prosecute a case of assault on elderly women in a nursing home, and I was going to refer it to the local prosecutor. He said, "Where is your victim?" My victim was 74 years old and incompetent to testify. She also was mentally retarded, and she was punched pretty hard in the face and slapped for defecating on her bed.

The local prosecutor told me, "We cannot prosecute this case because there is no victim; therefore, how do we know there was any harm in a punch and a slap to the lady's face?" I told him, "Have you ever had a murder case? There are no victims in murder cases." He didn't seem to understand that. He also didn't understand that you can prove harm to someone just by a slap, just by someone going back from the punch, or by other instances of conduct besides the victim telling you, "I was harmed." That case would have been dropped if the Medicaid Fraud Control Unit had not prosecuted the case itself. Therefore, as I said, training and assignment of judges and prosecutors in this area are extremely important. It seems the system has to be changed; it's still a problem in the United States, everybody still believes that it's just a domestic—police, prosecutors, and judges—and that has to be changed, and it is being changed, hopefully, through this hearing. Also the attitude that exploitation of the elderly, and abuse of the elderly, and neglect of the elderly, is a consequence of getting old and should be handled civilly; that's also a myth that has to be changed. So through legal and judicial reform, we hopefully can change the system.

[The prepared statement of Mr. Carluccio follows:]

RECOMMENDATIONS FOR ROUNDTABLE DISCUSSION ON ELDER ABUSE AND VIOLENCE AGAINST MID-LIFE AND OLDER WOMEN

Submitted By: Thomas E. Carluccio
Director Medicaid Fraud Control Unit
Deputy Attorney General
State of Delaware

BETTER REPORTING OF ELDER ABUSE

1. National uniformity with respect to definition of abuse and neglect.

2. Mandatory reporting by Long Term Care Ombudsman in order to "protect" victims.

PREVENTION OF VIOLENCE AND ABUSE

1. Mandatory criminal checks for licensed caretakers and employees for facilities.

2. Coordination of agencies such as the Long Term Care Ombudsman, Adult Protective Services, and licensing and certification so that guidelines for placement, and referrals of abuse are handled in a manner that protects them from aggressive caretakers.

3. Strengthen civil remedies in order to ensure that an abuser is excluded from the Health Care System and necessary personnel actions can be taken.

4. Amend legislation to extend the prosecutorial authority of the state Medicaid Fraud Control Units (MFCU's) to home and community caretakers of individuals receiving Medicaid benefits.

CRIME REFORM

1. Increased penalties in the form of minimum penalties for older person who are victims of violent crime and fraudulent activity.

   EX: Robbery 2nd Degree would become Robbery 1st Degree. Assault 3rd Degree would become Assault 2nd Degree, (If the victim is over the age of 65.)

   Theft by exploitation would be a higher degree of felony if the victim is over the age of 65.

2. Enact legislation that prosecutes elder abuse based upon the actions of the abuser and not based upon the results of the abuse; ie. the necessity to prove pain and suffering on the part of the victim who often cannot communicate the actual harm. The crimes of physical and emotional abuse need this type of legislation for prosecutions to be successful.

   EX: Delaware's Patient Abuse and Caretaker Laws.

3. Define "neglect" within the parameters of violent crime because the result may cause serious physical injury or death.

LEGAL AND JUDICIAL REFORM

1. Education of Judges and local prosecutors on the nature of domestic violence and elder abuse. Judges should be specifically assigned to handle abuse cases so that they may be aware of the nuances of the law and appropriate services and agencies that are involved.

2. Better definition and coordination with respect to state and federal agencies in tracking, referring, and investigating allegations of abuse.

3. To enact "protective order" legislation that allows Long Term Care Ombudsman and Adult Protective Services to remove abused victims immediately from their abusers.

INCREASED EDUCATION AND TRAINING

1. AMA guidelines from assessing domestic violence must include elder abuse and neglect.

2. Bank personnel must be educated with respect to laws that protect the elderly and recognize exploitation of an infirmed adult's resources.

3. Police and local prosecutors need political assistance, training, and resources to combat domestic and elder abuse. Since the victim often cannot or refuses to initiate prosecution the resources must be expanded to gather evidence and push prosecution for the protection of the abused. In order to gather the evidence needed for a successful prosecution much more time and expense may be needed than prosecution in other areas.

   EX: a. Tracking of financial resources of an infirmed adult who is reluctant or incapable of cooperating with law enforcement.

   b. Victims are often fearful or incapable of providing evidence of the abuse, and may be deceased when the case comes to trial.

Ms. ARAVANIS. Great, Tom, thank you.

Our next panelist is Elma Holder. Elma is the Executive Director of the Citizens Coalition for Nursing Home Reform. She is also Director of the Administration on Aging-funded National Long-Term Care Ombudsman Resource Center. Elma is known nationwide as an advocate for residents in long-term care facilities.

Elma, would you speak to some issue that you feel strongly about?

STATEMENT OF ELMA HOLDER, EXECUTIVE DIRECTOR, NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM, WASHINGTON, DC

Ms. HOLDER. Yes, thank you.

I want to specifically address, at least for the time being, the institutional-based elder abuse and neglect. I think one of the most tragic things that we have in our country is that people go into institutional care thinking that they're moving into a protected environment and a safe environment, and unfortunately we know that that's just not the case, regardless of the fact that we have a Federal law that is very strong that does assure for each person who lives in a nursing home that they will be free from neglect and abuse and that they will get good care. The fact is that we still have ongoing occurrences of actual abuse by people in facilities.

But I think more important than that is the fact that although we have very good care practices in nursing homes across the country and we know what good care is and know that it can be given, that in fact what we often have in institutional-based care is very poor care and neglect, which leads to the worst possible early deterioration of elderly women and men in facilities.

So I would like specifically, this round, to address—although I think the enforcement of the law is critical and is not happening, what is most important to me is that we prevent these abuses and neglect before it actually occurs.

So I would speak to your recommendations on prevention of violence and abuse, and also the increased education and training. I know that the Older Women's League has been extremely active over the last few years, very concerned about the caregivers in facilities; not only in institutions, but also in community-based care. I do think that it's critical that we have ongoing attention paid to the workers in facilities and in agencies because we know that so often they are untrained and so often so poorly supervised and working under very poor conditions.

So I think anything we can do to help empower and train the women—who are also women who are abused and neglected in their workplace oftentimes—that that is going to be a priority for me to hear this afternoon, as well.

[The prepared statement of Ms. Holder follows:]

QUALITY CARE GOALS

AND

PREVENTION AND DETERRENCE OF ABUSE AND NEGLECT

IN INSTITUTIONAL-BASED CARE

An Overview

Presented to Older Women's League and

Senate Special Committee on Aging

Roundtable Discussion on Ending Violence Against Midlife and Older Women

May 4, 1994

Prepared by Elma L. Holder
The National Citizens' Coalition for Nursing Home Reform
National Long Term Care Ombudsman Resource Center
1224 M Street, N.W.
Washington, D. C. 20005 (202-393-2018)

QUALITY CARE EXPECTATIONS IN INSTITUTIONAL CARE

Community expectations of quality care come from public policy set forth in the Social Security Act, (Public Law 100-203) Title C, Nursing Home Reform, enacted in December 1987, which became effective October 1, 1990.

RESIDENTS' RIGHTS

A set of residents' rights are assured for each person. These include forms of protection to prevent Medicaid discrimination and strong rights regarding any transfer or discharge of a resident. Also full access for the resident to the long-term care ombudsman.

QUALITY OF LIFE

The law requires each nursing facility to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." A new emphasis is placed on dignity, choice and self-determination for nursing home residents.

QUALITY OF CARE

Nursing facilities must provide care and services to "attain and maintain the highest practicable mental, physical and psychosocial well-being" of each resident.

- Mandatory training and competency evaluation for current and future nurse aides.
- Round the clock licensed nursing in all nursing homes, with an RN on staff every day. (With waivers offered for nursing facilities under special circumstances only).
- Full time social workers in facilities with more than 120 beds, with social services to be provided for each resident as needed.
- Qualified activities directors and dieticians in all nursing homes
- Comprehensive resident assessment of each person's needs and development of a plan of care to assure that each person "attains and maintains his/her highest practicable physical, mental and psychosocial functioning."
- Review, prior to admission and annually after admission, of all persons with mental illness and mental retardation to assure appropriate placement in a nursing home.
- Establishment of a Quality Assurance Committee in each facility to be composed of a physician and other health care professionals, to review and plan for action to make changes needed to assure quality care.
- More enforcement options against nursing homes that do not meet standards for residents' rights, quality of care and quality of life.

WHAT FORMS OF ABUSE OCCUR IN LONG TERM CARE FACILITIES?

An elderly person living in an institutional setting is typically extremely frail, often disoriented and ill. Impairments in vision and hearing and restricted mobility are common. Those with dementing diseases are often resistant to care, becoming difficult to help, particularly when staff are poorly trained staff to care for them.

Extra sensitivity and special caring is needed to handle staff day-to-day frustration and to prevent and deter forms of abuse described below.

PHYSICAL AND MENTAL

- direct abuse from a facility staff member, and sometimes an intruder or visitor from outside the facility

  (striking, pinching, shoving, pulling, force-feeding and various forms of sexual abuse)

- substandard health and personal care results in abuse. For example:

  incorrect or inappropriate use of restraints, both physical and chemical, often results in one or more of the following conditions - immobilization, incontinence, dehydration, pneumonia, cardio vascular stress, pressure sores, and psycho-social trauma.

- psychological\emotional abuse

  berating, ignoring, ridiculing, cursing, teasing a resident, and unnecessarily, inappropriately restricting mobility and misappropriation of property

DAY TO DAY NEGLECT

- an accumulation of neglectful practices result in abuse, for example:

  - incorrect positioning leads to contractures, skin breakdown
  - failure to provide adequate liquids leads to dehydration
  - sitting in urine and feces leads to indignity and skin breakdown
  - lack of assistance to eat leads to malnutrition
  - poor handwashing techniques leads to infection

SELECTED PROVISIONS RELATING TO ABUSE IN PUBLIC LAW 100-203

RESIDENT PROTECTION

The resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion.

The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

SURVEY AND CERTIFICATION PROCESS

Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State shall provide, through the agency responsible for survey and certification of nursing facilities, for a process for the receipt, timely review, and investigation of allegations of resident neglect and abuse and misappropriation of resident property by a nurse aide (or by another individual used by the facility in providing services to such a resident.) The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations.

If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority.

NURSE AIDE REGISTRY

The registry shall provide for the inclusion of specific documented findings by the State and any brief statement of the individual disputing the findings. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include the disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such statement.

A facility must not use any individual as a nurse aide unless the facility has inquired of the State registry as to information in the registry concerning the individual.
(Note: States should have an established registry operating; however, final federal regulations for the registry operation are still pending.)

THE LEGAL AND REGULATORY FRAMEWORK FOR PROVIDING AND ASSURING QUALITY CARE EXISTS IN PUBLIC POLICY; HOWEVER, ADDITIONAL ANALYSIS AND ACTION IS USUALLY NEEDED TO AVOID POOR CARE, NEGLECT AND ABUSE.

ANALYZING ABUSE IN INSTITUTIONAL CARE:

POTENTIAL CONTRIBUTING FACTORS

REGULATORY OVERSIGHT

* Ineffective/weak laws
* Ineffective/weak survey and enforcement system
* Ineffective/weak long term care ombudsman program
* Other ineffective/weak abuse monitoring/reporting programs

COMMUNITY INVOLVEMENT

* Lack of on-going presence and involvement from families, friends and volunteers

FACILITY STAFFING

* Lack of - or inadequate training in:
  - physical care of the elderly
  - behavioral issues and work with residents with dementia
  - stress reduction techniques
  - laws/regulations regarding abuse avoidance and reporting
  - sources of help
  - Residents rights and psychosocial needs
  - Participating in care planning
* Staff stress:
  - shortage of staff
  - double shifting of staff
  - poor or inadequate supervision
  - lack of programming for stress reduction
  - inadequate or poor training
  - lack of sufficient or appropriate supplies and equipment
* Poor or inadequate supervision:
  - lack of staff training in supervisory techniques
  - too few supervisors to effectively supervise
  - poor management for quality services

- Lack of involvement, guidance and supervision and service and treatment from qualified health care professionals, including nurses, physicians, social workers and other necessary therapists.

FACILITY MANAGEMENT

- Inadequate budgeting for/or solicitation of adequate numbers and correct mix of staff to provide good care
- Failure to pay competitive pay scales and benefits to attract qualified staff
- Inadequate screening of personnel
- Inadequate performance monitoring and evaluation
- Poor working conditions creating stress and staff dissatisfaction
- Inadequate training and administrative support for supervisory staff
- Inadequate provision of supplies-equipment essential to give good care
- Failure to implement programs and training to help staff handle stress
- Failure to implement and enforce an intra-facility abuse reporting system

WHAT ARE SOME OF THE THINGS ADVOCATES AND SERVICE PROVIDERS CAN DO ABOUT INSTITUTIONAL ABUSE?

MONITOR, EVALUATE, SUPPORT AND ADVOCATE for quality services from:

- Long Term Care Facilities and Health Care Professionals
- Long Term Care Ombudsman Program
- Licensure and Certification Agencies and Professional Licensing Boards
- Nurse Aide Abuse Registry
- Other Community Services and Programs which provide services to residents

TRAIN, EDUCATE, AND MOTIVATE TO CHANGE

Through dissemination and development of materials, training sessions, community forums and use of the media, involving:

- Owners and management of long term care facilities
- Staff of long term care facilities and other health care professionals
- Long Term Care Ombudsmen and volunteers
- Families and Friends, Resident and Family Councils, Church groups
- Adult Protective Services and Protection and Advocacy staff
- Medicaid Fraud and Abuse and Licensure and Certification staff
- Police and Prosecutors and Other Community Institutions and Agencies

ORGANIZING

- Solicit volunteers to assist (ombudsman program, facilities, etc.)
- Engage local/state organizations to respond to current issues and actions
- Recognition Programs to reward services of nurse aides and other staff or improve communications among staff, families and residents
- Facilitate reporting of abuse to appropriate agencies
- Monitoring and review of facility surveys in the community
- Support of resident councils and family councils

HOW NCCNHR and the NATIONAL LONG TERM CARE OMBUDSMAN RESOURCE CENTER

CAN HELP YOU IN YOUR

WORK TO SECURE QUALITY CARE, DETER AND PREVENT ABUSE

IN INSTITUTIONS

- **PROVIDE CONSULTATION AND ADVICE**
  - Federal laws and regulations
  - Model advocacy programs to prevent or address abuse

- **TRAINING AND PUBLIC EDUCATION**
  - Direct training on selected topics
  - Provision of model training program information
  - Referral to expert training sources
  - Speeches and assistance with media work

- **REFERRALS to experts and to state and local agencies which address abuse issue**
  - State and local long term care ombudsman programs
  - State licensure and certification programs
  - State and local protection and advocacy programs
  - State and local adult protective services
  - State Medicaid fraud and abuse programs
  - Citizen advocacy organizations
  - Health care professional organizations

Ms. ARAVANIS. Thank you, Elma.

Our next presenter is Pat Reuss. Pat and I just met for the first time today. Pat is with the NOW Legal Defense and Education Fund. I understand that she has an extensive background in issues that are of concern to older women: pensions, violence, civil rights, insurance, consumer rights, etc.

We are very pleased that you are with us as well, Pat. Would you like to speak to a particular issue?

STATEMENT OF PAT REUSS, SENIOR POLICY ANALYST, NOW LEGAL DEFENSE AND EDUCATION FUND, WASHINGTON, DC

Ms. REUSS. One of the proudest things that NOW Legal Defense Fund has done is chair a task force on getting the Violence Against Women Act passed. We are very close to it, and I commend you, having Senator Biden and Attorney General Reno—you were doing the best advocacy possible. You were standing next to them and they were "talking our talk and walking our walk."

I have lots to say and I have lots to submit for the record, fact sheets and lists of groups that care about this issue; also, lists of groups that care about this issue but don't have older women in their fact sheets. They haven't recognized, as OWL has, that there is a disproportionate silence—a dirty little secret, which is violence against women, often in the home. For older women it's dirtier and not very little and much more secret, so I think we have to address that.

Two things I want to talk about. When we collect the data, I beg us to collect it not only on all the wonderful things you have recommended, but on economic status. I have testified and begged and pleaded, working in the area of welfare reform—or on any women's issue—for the experts to recognize that over half the women in homeless shelters have run away from home because of violence, incest, battering, and assault. Even for men and women who are on some form of welfare or on their own or living alone, there is a direct correlation with violence. But we don't collect that data, so it's anecdotal.

So short of the Senate Aging Committee wandering with me in the homeless shelters and having the women tell their stories, I think that that would be an important addition, however we call it, because I believe it crosses all lines of economic status. I think it would also do us a favor to recognize that it isn't just poor women, but poor elder women, poor young women, poor any women.

Second, what I call cross-pollination, and it's sort of what we're trying to do today. For too many years the advocates to stop violence have been the victims themselves. They break out in tears; they aren't skilled politicians; they aren't experts. They tell their story, but then it sort of stays on the newspaper reporter's desk or whatever.

The other groups are the experts. Sometimes the experts are wonderful, but they also aren't skilled politicians. They also don't give speeches to audiences of OWL members or NOW members, or they talk to their colleagues who all agree and nod their heads, do papers on it, papers that the advocates don't read.

And then the third group, the pollinators, are the Older Women's League and BPW and the General Federation of Women's Clubs and the NOW members and all the advocates, the unions, the churches, the groups that we've pulled together in the Violence Against Women Act task force that are professional advocates. Whether they're paid or not, they're do-gooders; and whether they've been battered or not or know anything about that, they know it's bad, and they'll walk the halls of the city, county, State, and Federal legislatures. And that's been the beauty of why I think we're almost ready to see the passage of the Violence Against Women Act.

So I think OWL has an important role in all of these things that we're going to do in building the bridges, holding hands with our experts on the one hand and our victims on the other, and then telling the story in the vernacular that I think our country needs.

Ms. ARAVANIS. Good. Thank you, Pat.

Our next panelist is Dr. Toshio Tatara. Toshio and I have been working together, with many people around this table, for the last 10 or so years on the issues of elder abuse. Toshio works for the American Public Welfare Association. He works very closely with States and counties on a number of different issues. He is currently the Director of the Administration on Aging-funded National Resource Center on Elder Abuse.

Toshio, if you would give us your perspective on some of the recommendations.

STATEMENT OF TOSHIO TATARA, Ph.D., DIRECTOR, NATIONAL CENTER ON ELDER ABUSE, WASHINGTON, DC

Dr. TATARA. Thank you for this invitation. I am very pleased to be a part of these proceedings.

You know, I have the reputation of being long-winded and boring; so I would like to avoid a long speech.

I am very appreciative of the fact that the recommendation pertaining to the data and research is among the strong recommendations that were made by this report. For someone that is involved in data collection, not only in this area but in child abuse and foster care and adoption services in the past 10 years or so, this recommendation makes a lot of sense, not only to me but to the people that we represent.

From the standpoint of human lives, one victim is one too many; but from the standpoint of social policy, there is a difference between 100 victims and 1,000 victims or 100,000 victims. I think that we professionals owe it to the victims and at-risk elders and all those people we work with, that we generate accurate data so that we can be effective in our effort to advocate for their well-being, and also in any professional efforts that we engage in.

Another area that where I am impressed with this report is the recommendation to call for greater advocacy and coordination at the local level through the center activities. We have been advocating for greater coordination and collaboration among agencies and organizations and individuals that are concerned with all forms of family violence; not only with elder abuse, but with other forms of violence that takes place, not only in domestic settings but in institutional settings as well. So I commend you on this and the other

recommendations which are timely and ought to be listened to not only by policymakers but researchers and advocates and administrators and all the other people who are concerned with all forms of violence in our society.

Thank you.

[The prepared statement of Dr. Tatara follows:]

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Toshio Tatara, Ph.D., Director

Comments on the Older Women's League (OWL)'s Report, "A Mother's Day Call to Action: Ending Violence Against Midlife and Older Women."

Toshio Tatara, Ph.D.
Director
National Center on Elder Abuse (NCEA)
Washington, D.C. 20002

On behalf of the National Center on Elder Abuse (NCEA), I would like to congratulate the Older Women's League (OWL) on their timely release of the above-mentioned report. The report contains many important recommendations that need to be studied by policymakers, community leaders, educators, researchers, and practicing professionals concerned with all forms of violence against vulnerable persons. My comments address only OWL's recommendations for which I personally have expertise, and other members of NCEA are expected to provide their comments on other areas based on their expertise.

- The recommendation that data on elder abuse victims must be disaggregated by gender makes good sense. NCEA will carefully examine its current data collection guidelines and instruments (as well as states' capabilities to produce elder abuse data) and will try to incorporate this recommendation into the Center's future data collection design.

- NCEA agrees with the recommendation that the (national) incidence and prevalence of elder abuse must be studied. In addition to continuing to collect and analyze data on elder abuse reports generated by states, the Center plans to conduct the nation's first study of national elder abuse incidence and prevalence, collecting data from a nationally representative sample of elderly people.

- OWL's recommendation that studies of risk factors for elder abuse need to be conducted is most appropriate because findings of such studies can help improve elder abuse prevention activities. NCEA's current work plan includes a study of the use of risk assessment tools and outcomes. In addition, the Center's proposed national study of elder abuse incidence and prevalence is expected to identify a range of risk factors associated with victimization of elderly people.

- Elder abuse data on race/ethnicity are very scarce, and little is known about what role race and ethnicity play in the incidence of elder abuse. OWL's recommendation that research is needed on the role of race and ethnicity in violence is very appropriate. NCEA (which currently does not collect data on race and ethnicity) will examine its data collection guidelines and instruments, as well as states' capability to generate race/ethnicity data, in an effort to incorporate this recommendation into the Center's future data collection efforts.

- OWL recommends that a study must be conducted to examine whether the elder abuse provisions under the Older Americans Act should mandate state reporting of elder abuse data. NCEA supports this recommendation, although it is doubtful that simply requiring states to report this elder abuse data will immediately lead to an increased availability and greater comparability of elder abuse data from states. States would agree on the importance of data, but it does not appear that they currently have sufficient resources to invest in efforts to quickly improve their elder abuse information systems. One could argue that if the federal government wishes to mandate reporting of elder abuse data, they should make federal dollars available to subsidize states' efforts to revamp their information systems (as it is currently being done in child welfare).

- Similarly, NCEA also supports OWL's recommendation that uniform definitions must be used by all states in the reporting of their elder abuse data. Realistically speaking, however, the Center doubts that uniform elder abuse definitions will be achieved across all states within a short period of time, unless an enormous amount of federal funds, along with intensive technical assistance, will become available. Given that the likelihood of any federal dollars being allocated for improving state elder abuse information systems is very small, what one can most hope for is to achieve greater compatibility of elder abuse definitions through voluntary efforts by states. NCEA plans to assist states in these efforts with technical assistance and training.

- OWL recommends that a specific percentage of each states' Social Services Block Grant (SSBG) allotment should be used for adult protective services. NCEA cannot comment on what each state's policy should be regarding the allocation of SSBG funds across different program areas. However, expenditure data on SSBG collected by the American Public Welfare Association's Voluntary Cooperative Information System (VCIS) reveal that only 3.1% of the total social service funds were spent for productive services for adults and the elderly in 23 states that provided complete data in 1990. This percentage was about one-fourth of the percentage of social service funds spent for protective services for children (11.8%) in the same year.

- NCEA supports OWL's recommendation that adequate (joint) training for long-term care ombudsman and adult protective service personnel should be provided. Currently, about 17 states make adult protective service workers responsible for investigating reports of institutional elder abuse. Some other states report that long-term ombudsman and adult protective service programs work very closely at the local level. One of NCEA's task is to facilitate closer working relationships among county social service departments, local ombudsman programs, and area agencies on aging, and the staff of the Center has already begun discussion with officials of the National Association of Counties (NACo) and of NACo's affiliate organizations on aging. It is likely that the topic of joint training for workers from different local programs concerned with elder abuse will be on the agenda of future discussions.

- One of OWL's recommendations is to set up hospital-based elder abuse projects for early detection, screening, and investigation. NCEA supports this recommendations and plans to identify and describe existing "exemplary" models of hospital-based elder abuse programs for the purpose of disseminating to the elder abuse/neglect network.

- Finally, NCEA agrees with OWL that there should be greater coordination between courts and social service agencies in the handling of elder abuse cases. The staff of the Center has already begun discussing with representatives of both the National Center for State Courts and the National Council on Juvenile and Family Court Judges in an attempt to find ways to collaborate between the Center and these organizations.

Finally, the views and interpretations of facts presented in this paper are those of the author and do not represent the policies of the consortium organizations that operate NCEA or of the Administration on Aging (AoA), which supports the operation of the Center. References to NCEA's current work plan are factual, but any references to future work plans of the Center are based on the author's best estimates.

Ms. ARAVANIS: Great. Thank you, Toshio.

Our next panelist is Dr. Terry Fulmer. Terry is the Associate Dean for Research at the Columbia University School of Nursing. Terry has been in the elder abuse field for many years, as well. Terry has had many roles in this arena, all the way from opening clinics for abused elders to actually educating health professionals.

We are most grateful to you, Terry, for having educated a lot of physicians so they know much more about the whole arena of elder abuse. If you would, please, speak to us a bit about an issue that you feel strongly about.

STATEMENT OF MS. TERRY T. FULMER, Ph.D., ASSOCIATE DEAN FOR RESEARCH, COLUMBIA UNIVERSITY SCHOOL OF NURSING, NEW YORK, NY

Dr. FULMER. Thank you, Sara, I will. And I want to thank OWL, and in particular Anne Riley, for making this day possible.

I will be speaking with two voices for the next couple of moments, one as a registered nurse, 1 of 2.4 million nurses in this country who come in contact with older individuals every day; and second, as a researcher. My remarks are certainly colored by both those roles.

With regard to a passion that I have for a product, it is that of a minimum data set that we can develop from existing documents with, I believe, modest Federal funding so that we understand the state of abuse against women and abuse against the elderly in this country. We have 43 States that are collecting data; I think that a minimum data set (MDS), gleaned from what already exists in file cabinets across this country would be an absolute boon to this whole topic by way of understanding the issues. And I think that that's a relatively modest request that can happen. When you compare that to what OBRA 1987 did for restraints, in about the course of 3 years we saw the untying of the elderly. We can do the same on this issue. We can get it on the table; I really believe that firmly, and as a nurse who has worked in nursing homes, I feel that strongly.

The points that I think that an MDS could speak to are as follows:

The clarification of institutional abuse versus home abuse, the commonalities and differences, because they are different;

The abuse that is done by paid caregivers versus unpaid caregivers, again, not a trivial difference, a licensed caregiver versus an unlicensed caregiver, and make sure that we stop putting these people together in the same goulash pot. It is not okay for a paid nursing assistant or registered nurse to leave somebody on their side to the point where they get whopping decubital selsa when we might see a different way for a 92-year-old spouse the first time; and

Clarify the following: We keep removing elders from their homes when they are victims of abuse. This is their number one fear, by the way, according to Harris Polls. However we get at it, I would like us to worry about that as an action. These are their homes. Removing the men or the people—sons or grandsons, or whomever has moved in with them—according to my practice, is a huge problem. Shelters? Well, temporarily,

but their home is their home, so there's a point of clarification that I think we can address.

Let me speak very briefly about the National Institutes of Health, and in particular the National Institute on Aging which has had a special meeting, a couple of years ago, on elder abuse under the direction of then-acting Jean Colin. Let me say where our science is. To date we had three RO1s, and for those of you who don't have to live the world of RO1s, congratulations, but in the academic setting those grants are the lifeblood to understanding our areas of research. NIA has funded three elder abuse RO1s over the past 10 years: Karl Pillemer, Mark Lachs, and Ricki Hudson. Actually, Mark's was a first award, which is a little different.

But that's a very minimum amount of research dollars invested, and I think we can do better. I'm hoping that we can lobby for a special request for proposals.

I also want to speak briefly to Sara's point with my 1 minute left about the medicalization of elder abuse. I see that as positive. You can see it negatively, but in capturing the attention of the health care system and "medicalizing," as I put it, the elder abuse and mistreatment, you are capturing a market that can get to isolated elders in a way that few other groups can. We see them in their vulnerable states when they have to come to a clinic for something or when a visiting nurse has to go out, and that's why I pound the pavement of those groups. I was thrilled when the American Medical Association finally got out their guidelines.

So in summary, I think we need the funding for research. We have to have that MDS so that we can get to the subissues, and I believe that foundations that are currently supporting it, like the Brookdale Foundation that funds my research, like the Stroud Center at Columbia, and like the Connecticut State Office for Aging VOCA funds, give us a good leg up so that the Government can really make a move.

[The prepared statement of Dr. Fulmer follows:]

Response of Terry Fulmer, RN, PhD, FAAN
Anna C. Maxwell Professor
of Nursing Research and
Associate Dean for Research
Columbia University School of Nursing

Response to the report of the Older Womens' League
"A Mother's Day Call to Action: Ending Violence Against Midlife and Older Women"

May 4, 1994

Special Committee on Aging: US Senate

The health care arena is at a critical juncture given the call for health care reform and the new demands placed upon an ever increasing violent society. To that end, the focus of my response to this Report is centered on the effective use of health care personnel in ending violence against women. The entire health care entity as we know it is is very actively engaged in research, practice, and teaching across a number of venues. It makes infinite sense to tap this major personnel source in order to educate women about prevention of violence, services for victims, and to engage them in the research questions that need answers in order to stem the epidemic of violence and mistreatment against women and in particular, older women in this country.

The Women Health Initiative at the National Institutes of Health is an example of a program that could ultimately be a very strong partner in the crusade against violence. Domestic violence **is a woman's issue and aging is also a woman's issue** given the life span of women. The Women Health Initiative has plans underway to find important health problems related to women. I believe that **violence is an important health problem for women.** The sequelae of such violence brings women in droves to our emergency rooms, clinics and shelters. The Women's Health initiative can play an important role by calling for a research agenda to obtain data on this issue and fund it.

Practicing clinicians are another avenue for stemming the tide of violence against women. There are currently 2.4 million registered nurses in this country and if mandatory training on Violence Against Women was required for licensure, or relicensure as it is in New York for child abuse, we would be able to educate these professionals in a way that could inform their practice. Similarly, if programs for physicians and social workers which were mandated for relicensure could do the same. This would bring a massive influx of people into the assessment and detection realm for victims of violence and abuse. Ultimately this, would provide us the information to really strike at the heart of the matter "prevention."

Research is crucial to stemming the tide of violence against women. To date, we have no national database that enables us to look at violence against older women and describe trends geographically, demographically, or culturally. We have no way to translate the experience of the elder women in New York to the elder women in New Mexico. Such data are essential and have been called for for over 10 years. Currently, over 40 states have mandated reporting laws and voluntary data collection within their state agencies. With a very modest financial outlay, **I believe that a minimum data set (MDS) from violence against the elderly, could be generated which would give us a clear picture of the prevalence, nature of the problem, and mechanisms for prevention.** For example, if the National Center for Elder Abuse was responsible for collecting an annual report from each State and was able to glean from each an MDS, that could be truly made available, effective studies could be launched.

Financial support for databases, researchers, Federal programs, and public awareness campaigns can never be too expensive. Violence against women and older women is an expensive embarrassment to our Society and through effective partnerships with the health care system, an influx of individuals who are prepared to make a difference will stem that tide.

Ms. ARAVANIS. Great. Thank you, Terry.

Our next panelist is Maria Brown. Maria and I just met in the last half hour or so. Maria comes to us from one of the most respected Area Agencies on Aging in the State of Pennsylvania. Maria is with the Philadelphia Corporation on Aging. She is a planner there, and she is joining us to speak about some of the local issues or issues that she sees from the local arena related to this.

Maria, would you give us your comments on this study, please?

STATEMENT OF MARIA BROWN, PLANNER, PHILADELPHIA CORPORATION FOR AGING, PHILADELPHIA, PA

Ms. BROWN. Yes, thank you, Sara.

I am relatively new to the area of elder abuse, but I spent almost 10 years in the domestic violence field. I will, as Sara suggested, really speak from the understandings I've developed in Philadelphia at the Philadelphia Corporation for Aging, the local Area Agency on Agency, which is the designated organization that responds to elder abuse in Philadelphia.

I would have to agree that complexity is what describes our experience, as Joan earlier pointed out, in reference to older women's lives. The profile of the victim that we encounter is of a white aged woman with multiple chronic illnesses, and very often with declining clarity. These victims very often—almost uniformly—prefer to remain in their familiar setting, in their own home, largely, which is where the violence happens, or in a smaller proportion of cases, in the caregiver's home. Given the marked scarcity of other options, lots of our efforts are directed to trying to explore how to maintain victims safely in their own homes. So the recommendations that OWL makes along the lines of greater social service support are those that really speak effectively to the challenges.

The recommendations regarding expanded home and community-based services clearly would respond to the kind of overburden that many caregivers wrestle with—often unsuccessfully, often. The notion of improved and expanded guardianship—in Pennsylvania, for instance, we don't have an Office of Public Guardianship.

In general, any support for expanded intensive care management would be critical to the types of urban elder abuse, largely affecting, as I said, very elderly women, that we encounter, any ability to bring more services and support to facilitate victims remaining safely and stably in their own homes. At this point that seems to be the only realistic way to address the immediate suffering that we see.

The other recommendation that was very appealing, and I did circulate OWL's recommendations widely in our Protective Services Unit, had to do with what you call the "empowering services," particularly this telephone-based support kind of service, where basically women's support groups could operate on a telephone basis. That made a lot of sense to our Protective Service investigators and other staff. There aren't ongoing ways to have continued contact easily with victims who literally can't get out of the house and have only the telephone line as a connection to the outside.

[The prepared statement of Ms. Brown follows:]

May 4, 1994

Response to Older Women's League's **"A Mother's Day Call to Action: Ending Violence Against Midlife and Older Women"**

Older Women's League 1994 Mother's Day report sets forward a notably comprehensive and well-targeted set of recommendations to address elder abuse and violence against midlife and older women. The recommendations OWL outlines speak to the range of institutional arenas, levels of government as well as short-term and longer-term action that must be addressed to respond to the diversity and scale of violence midlife and older women face in this country. I would like to highlight those recommendations that are most relevant to the experience encountered at Philadelphia Corporation for Aging (PCA), the area agency on aging, which is the designated agency responsible for investigating and responding to elder abuse in Philadelphia.

In fiscal year '93, Older Adult Protective Services (OAPS) at PCA responded to 2,423 reports of elder abuse. Self neglect was the leading form of abuse reported, appearing in 2 out of 5 cases (40%). Just less than 1 in 4 reported cases involved neglect by a caretaker (23%) and a similar proportion of cases involved financial exploitation (22%). Emotional abuse was implicated in 1 in 6 cases (17%) while 1 in 10 involved physical abuse (10%) and 1% of reported cases included sexual abuse. (Some reported cases involved more than one form of abuse - hence, breakdowns by type of abuse total in excess of 100%).

Victim profiles suggest that 7 in 10 older persons abused were women. Age-wise, 3 in 5 victims were 75+ (59%) while another 1 in 5 (17%) were between 70-74. The balance of victims were younger than 70 (34%). Just more than half of victims were Black (53%) while 43% were White; 2%, Hispanic and the balance, a sampling of other races/ethnicities (3%).

Women were reported as perpetrators, compared to men, at a 3:2 ratio (59% versus 41%). Seventy percent of abusers were between 30-59 years of age while 10% were less than 30 and 20% were 60+ in age.

The modal relationship of perpetrator to victim was nonrelative. Two in five perpetrators had no family tie to their victims. Women were represented almost twice as often among these abusers, representing 26% of all perpetrators while unrelated men accounted for 14% of all abusers. One in three of all perpetrators were children of victims (33%). Daughters (17%) only narrowly outnumbered sons (16%) as perpetrators. The next largest category of abusers were other relatives of victims (14%). Again, female relatives were represented somewhat more often than male relatives (8% versus 6% of all abusers).

Three out of four reported elder abuse cases happened in the home of the victim (75%) while in 8% of cases, the caretaker's home was the site of abuse. The balance of cases happened in institutional settings like nursing homes, private care facilities and other congregate living arrangements.

As for outcomes, 43% of closed cases resulted with resolution of the reported problem while 28% of clients refused service and 16% were placed or transferred to long term care facilities. In the balance of cases, clients were directed to other outcomes or died (13%).

Three scenarios lie behind these statistics. The situation of elder abuse most frequently encountered in Philadelphia involves quite aged women whose cognitive clarity and physical functioning have declined and who have outlived their support network. These women slip into self neglect without the financial resources to purchase supports to sustain themselves stably in their own homes and without the mental clarity and physical stamina needed to establish social service and other connections.

Another significant situation of elder abuse we encounter involves the victimization of frail elderly, predominantly women, by nonrelated perpetrators looking for a source of housing and income to support an addicted lifestyle. These younger perpetrators to secure their own needs by attaching themselves to vulnerable older persons no longer able negotiate the daily demands of living. The income of the older person is usurped and diverted to finance the perpetrator's needs and, in consequence, the living situation of the vulnerable elder rapidly deteriorates, putting the older person's survival in jeopardy.

A third often encountered situation of abuse involves the overburdened caretaker who, due to stress and/or ignorance, cannot manage the demands of caregiving for a frail older person, limited by multiple chronic illnesses. These caregivers are pressed beyond their limits and often don't know about resources that might lighten and relieve their burdens and create a better situation for both them and the frail older person.

A variety of the changes OWL recommends speak quite effectively to the scenarios outlined. Preventative measures like expanding home and community-based care would relieve the situation of overburdened caregivers, forestalling the kinds of stress that now lead to abuse of dependent older persons. Guardianship training and the incorporation of procedural safeguards in guardianship proceedings would encourage more competent and accountable performance on behalf of those who can no longer manage vital decisions on their own behalf. In general, more funding for intensive care management services would ensure the needed range of services and ongoing monitoring necessary to support many vulnerable older adults continuing to live safely and stably in their own homes, thereby precluding self neglect and/or vulnerability to opportunistic "help" or caregiver stress.

Specific educational and training-related recommendations OWL calls for clearly address the major scenarios we so often encounter. Training of health and nursing professionals, law enforcement and court personnel as well as social service workers, ombudsmen, protective service staff and care managers would improve the capacity available for assessing abusive situations, intervening and providing follow up and monitoring of cases. Emphasis on coordination of existing services across disciplines and systems -- particularly between courts and social services -- would make more effective use of available resources by maximizing impact in regard to elder abuse.

Lastly, many of the recommendations for creating/expanding "empowering" services for women fit the realities and needs of the vulnerable older female victims we see -- e.g. telephone support counseling, expanded violence hotline and shelter services.

I thank you for providing the opportunity to share our experience in Philadelphia and to comment on how OWL's recommendations for addressing violence in the lives of older women relate to needs of victims we serve.

Maria Brown

Ms. ARAVANIS. Thank you, Maria. We'll be back to you for some more of those good ideas on these issues.

The next panelist is Handy Brandenburg. Handy comes to us from the State of Maryland, where he is the Supervisor of Adult Protective Services. He is here today also as a representative of the National Association of Adult Protective Service Program Administrators.

Handy, if you would speak to an issue that you feel strongly about?

STATEMENT OF HANDY BRANDENBURG, PROGRAM MANAGER, ADULT PROTECTIVE SERVICES, BALTIMORE, MD, REPRESENTING THE NATIONAL ASSOCIATION OF ADULT PROTECTIVE SERVICE ADMINISTRATORS

Mr. BRANDENBURG. I would also like to thank OWL and the Senate Special Committee for this opportunity, both on behalf of myself and the Association of APS Administrators.

As I looked through the OWL document it just struck me that there were so many areas in which we have a commonality of interest, and that this kind of dialogue is the kind of thing that has to increase. To pick one, at Sara's insistence, I kind of went back through the list and picked out a part of the OWL recommendations that talk to the area of policy reform and implementation, dealing with coordinating commissions on violence—and I think the idea of coordination is a good one, but there is a sentence in that section that says that "violence cannot be dealt with in isolation; there must be a holistic approach." That hits a really strong chord with me as an Adult Protective Services Administrator. For those of us in the States in Adult Protective Services, for the most part—and there are some exceptions—Adult Protective Services deals with people who are 18 and over.

In no way do I want to diminish what we are talking about today, and that is the impact of the kinds of violence that we are talking about on women, on elderly women in particular, and I'm glad that today I finally found out what "midlife" means. I think the working definition is 45; I wasn't clear about that when I came through the door.

But I think that the affirmation that violence cannot be dealt with in isolation struck a chord in some of the things I heard this morning when Senator Biden talked about how violence shouldn't be talked about solely as domestic, that is, something that happens in the home or that is private. When Senators Pryor and Cohen talked about raising the level of outrage to violence, for APS it is primarily about elder women, but it's not just about that population. I think the idea of raising the level of outrage to violence for all populations is something that we need to be thinking about.

I think it also strikes a chord with what Attorney General Reno said about looking at violence in the community and picking it off, a piece at a time, because for those of us in Adult Protective Services, certainly we are concerned about the impact on elders, on elderly women, on midlife women. We are also concerned, though, about younger populations, the developmentally disabled, the mentally ill, the head-injured—there are lots of different populations that I could name, and I think that this kind of a dialogue is an

important one in that we continue to look at ways where we can fit together and learn things from each other.

In my eyes, this roundtable was pulled together very quickly, at least from the point of view of the way I got involved. Next week, funded with VOCA-Victims of Crime service dollars, we are having a conference in Maryland, "Serving Crime Victims." For the first time there will be as a part of that conference a panel that will deal with Adult Protective Services, aging, Medicaid fraud, law enforcement, and licensing and certification, and how those entities impact on what we have traditionally called "domestic violence" or violence against what is primarily a female population. In addition to the Adult Protective Services panel there will also be one on children.

So I think that as we bring these things together we do in fact need to look at where our commonalities are, and perhaps maybe where some of our differences are, so that we can be clear about how we are proceeding.

[The prepared statement of Mr. Brandenburg follows:]

Policy Roundtable:
Elder Abuse
And
Violence Against
Midlife And Older Women

Remarks by:
Handy D. Brandenburg, M.S.W., L.C.S.W.
Maryland Department of Human Resources
Adult Protective Services Program Manager.

National Association Of Adult Protective Services Administrators -- Treasurer and member of Association Executive Council.

Thank you for the opportunity to participate in the Policy Roundtable on Elder Abuse And Violence Against Midlife And Older Women. I am happy to bring to the dialogue my perspective as an Adult Protective Services (APS) Program Manager and a member of the National Association of Adult Protective Services Administrators (NAAPSA).

It is heartening to have the Senate Special Committee On Aging and the Older Women's League (OWL) join together to convene this important dialogue among those with interest in family and community violence.

From the perspective of an APS administrator, there is much in the OWL report to be affirmed and applauded. It was somewhat remarkable to review just the main headings of the OWL draft material and to see the commonality of interest we hold:

- Research and Data Collection
- Reporting
- Policy Reform and Implementation
- Preventive Measures
- Education and Training
- Empowerment
- Legal and Judicial Reform

At the same time, there are also some comments and recommendations to be made.

Not so long ago, the House Select Committee On Aging issued another report that highlighted a "decade of shame and inaction" related to Elder Abuse. Many of the issue raised in that document still are of value and need not to be lost sight of.

For State and for Adult Protective Services Units there are perhaps additional issues on interest. All are related to the over-arching issue of violence about which we are all concerned. Perhaps in some areas our interests are congruent. Perhaps, in others they diverge somewhat. They seem to have a great deal in common.

Some comments and observations from the Adult Protective Services perspective:

- For the States, Adult Protection is not an issue limited to the elderly -- although they make up a large proportion of the Adult Protection population; or to midlife women -- although their presence in the Protective Service population is important also. **For States it is an issue about adults of all ages.**

- An issue of importance for Adult Protective Services is the **vulnerability -- the greater impairment -- of adults at risk.** Battered women, victims of crime, and some of the other populations about whose treatment we are concerned, are sometimes more "well" and "able" when compared with the populations targeted for Adult Protection.

- For APS, the **incidence and seriousness of sexual abuse among vulnerable, impaired populations is a growing concern.** Certainly issues of research, education, reporting, treatment, etc. are of great importance to APS in this area.

- For APS, **the phenomenon of self-neglect is great importance.** In a study conducted by the National Association of Adult Protective Services Administrators that issue was clearly identified as part of the Adult Protective Services area in many jurisdictions. As with much of Adult Protection, it brings APS administrators to complex issues such as protection versus autonomy, competence versus impairment, and state versus personal interests. Self-neglect cannot be left out of the public policy discussion, research, etc. as our dialogue continues.

- For APS, **the role of Federal assistance and support is an important issue.** The House Select Committee On Aging report to which I referred earlier is telling in its portrayal of the amount of State budgets devoted to Child and Elder Protective Services: for children an average of $45.03 -- for elders an average of $3.80. The ability of States to go it alone in the area of Adult Protection -- noting that it includes other populations than elders and midlife women -- is questionable and merits examination.

Certainly the issues are not easy ones. This type of dialogue is important. APS programs typically serve populations age 18 and older. Programs for battered women and victims of crime also have bearing on other populations. The research, outreach, education and other activities that we (individually and in collaboration) pursue need to encompass a broad population, if for no other reason than to determine whether and in what ways their needs and risks -- and how we can best respond -- vary in origin, nature and intensity.

In closing, let me say that APS personnel have often had the opportunity to hear the stories of badly abused women and crime victims. One reaction we sometimes have is that if we overlay on those vivid pictures issues of impairment and vulnerability such as Adult Protective Services commonly deals with, the picture can get very much more complex, dangerous and frustrating. It is good that we are talking together in a common Public Policy Forum.

Ms. ARAVANIS. Good. Great. Thank you.

Moving around our circle here, our next panelist is Rosalie Wolf. Rosalie comes to us from the Medical Center of Central Massachusetts in Worcester, Massachusetts.

Rosalie wears many hats. She is also the Chairwoman and Director of the National Committee for the Prevention of Elder Abuse, and she also is a partner in the Administration on Aging-funded National Resource Center on Elder Abuse. She has a long history of research in the arena of elder abuse and is one of the experts that everyone calls on when they need to know the latest facts about this dilemma that we're dealing with.

Rosalie, if you would speak to us about an issue that you particularly care about?

STATEMENT OF ROSALIE S. WOLF, Ph.D., PRESIDENT, NATIONAL COMMITTEE FOR THE PREVENTION OF ELDER ABUSE, WORCESTER, MA

Dr. WOLF. Thank you, Sara.

First of all, I applaud the efforts of OWL and the Special Committee on Aging for making this afternoon possible and for the opportunity for me to be here.

I am going to just briefly state two points that have already been mentioned, but I think they need to be emphasized. First, I was very pleased to see research and data collection at the top of the list.

I do not think we know much more about elder abuse than we knew 10 years ago, which is shameful. Terry Fulmer has already spoken about the lack of research. In addition, the issue of State data collection deserves attention. For good policymaking or planning, we need to know what is happening and to whom it is happening.

Even with the efforts of Dr. Tatara, it has not been possible to obtain national evidence data from State reports. We need to have Federal support or at least Federal and State support to create an effectual data collection system.

The second point has also been mentioned, and that is the need for system coordination. One of the most positive outcomes of the elder abuse movement is the development of coalitions at the community level. We now realize that this issue of elder abuse cannot be handled solely by the aging network or by APS, but requires many participants. For the first time in the aging field—and I have to admit that it's been over 30 years—I have seen the coming-together of many sections of society which has been very exciting. During the past year or two, that collaboration has extended to include victims of family violence or institutional violence.

I would like to see the OWL action plan emphasize the need and value of system coordination, and support efforts to make sure that communities go in this direction. There is a number of coalitions or consortia across the country, but we need to expand the number.

[The prepared statement of Dr. Wolf follows:]

National Committee for the Prevention of Elder Abuse

RESPONSE OF

Rosalie S. Wolf

President, National Committee for the Prevention of Elder Abuse

to the report

of the Older Women's League

"A Mother's Day Call to Action:
Ending Violence Against Midlife and Older Women

The National Committee for the Prevention of Elder Abuse applauds the Older Women's League and the U.S Senate Special Committee on Aging for arranging this round table to discuss the recommendations of the OWL's "Mother's Day Call to Action: Ending Violence Against Midlife and Older Women." As an organization dedicated to promoting research, advocacy, education, and training on behalf of abused and neglected older persons and disabled adults, we are extremely pleased to join with you in your efforts to develop "sound public policy and innovative solutions to the abuse, neglect, and exploitation of older women." The comments below are my personal reaction to the recommendations as they relate to elder abuse.

Increased Research and Data Collection

Particularly noteworthy in the report is the emphasis given to research and data collection. It is shameful that so much of what we know about elder abuse is based on untested beliefs rather than serious research. Too much reliance has been placed on invalidated and unreliable measures and small and unrepresentative samples. Unlike other forms of family violence that have been the subject of many studies in the past decade, not much more is known about elder abuse than was revealed ten years ago. Pillemer[1] (1993) attributes the lack of credible research to the fact that few researchers have found the topic to be one of enduring interest. He notes that when child and spouse abuse were "discovered," many social scientists became involved with the subject which energized the research area. Such a commitment to elder abuse has not happened. The "larger mainstream gerontological research community has not shown interest in the topic".

As suggested in the OWL report, such basic questions as the prevalence and incidence of abuse, risk factors, barriers to seeking and accepting help, and the role of ethnicity and race in the perception of violence still remain unanswered. Despite the hundreds of programs that are dealing with mistreated elders, very few have been subjected to a systematic evaluation. Support to encourage research must be included in future public policy along with some serious attempts to interest the research community in our issues.

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[1] Pillemer, K. (1993). *Working paper No.1: A report on the proceedings of the 1st International Symposium on Elder Abuse.* Staffordshire: The North Staffordshire College of Nursing & Midwifery and the University of Keele.

Better Reporting of Elder Abuse

Incidence data at the state level are generated in the most rudimentary form, with only a few exceptions. Such basic national information as age, race, and gender of victims and perpetrators, cannot readily be obtained. The experience of the National Aging Resource Center on Elder Abuse in compiling incidence data demonstrates very dramatically the inadequacies of the present systems for generating national statistics. Inconsistencies among the states as to the basic unit of measurement, eligible age, and definitions of abuse and neglect make it almost impossible to obtain a national picture of the problem. Further difficulty arises when the report includes multiple types of mistreatment. Separating out self-neglect and self-abuse cases from neglect and abuse by others is still not readily attainable.

To obtain national incidence data will require the states to use a uniform set of definitions. Given the status of their data management systems and their financial situation, it is unlikely that the states could accept this responsibility. However, it is very important that these statistics be available for planning and policy purposes both for the states and the federal government. A shared arrangement should be worked out in which both the federal and state governments contribute to the development of a national reporting system.

Increased Education and Training

Training for health care providers in identification and treatment of domestic violence, sexual assault, and elder abuse is a priority concern. Whereas members of the medical profession were important players in the discovery and conceptualization of child abuse, they have had little if any role in the domestic violence movement or in elder abuse. Consequently, physicians at all levels must be trained regarding the nature of these problems, their identification, and sources of referral. Content on these topics should be in the medical school curriculum, the clinical experience in graduate medical education, and continuing medical education programs. At the same time, efforts should be made to have questions on these problems inserted in the national board examinations to ensure that they will be part of the curriculum.

The reaction to the first reports on the training of bank personnel about financial exploitation of older persons has been very positive. However, much more needs to be done. Some funding, perhaps through the Administration on Aging, should be available to develop and disseminate the curriculum, similar to the project undertaken by the Police Executive Research Forum on law enforcement training.

Empowerment

Assertiveness training, elder rights promotion, and self-advocacy education are powerful abuse prevention strategies. Underlying these efforts is the assumption that all persons have the right to live free of fear and intimidation. Some older people will tolerate destructive behavior and mistreatment rather than seek help whether because of guilt, shame, low self-esteem, emotional ties to the offending family member, or cultural values that emphasize family solidarity above individual well-being. Education and training seminars in assertiveness, elder rights, and self advocacy can help to build self-esteem, self-confidence, and coping skills. Such programs can be incorporated within educational series on "healthy living" and can be offered through a variety of community sponsors. Support groups, a more intensive therapeutic approach, have also been shown to help older persons understand their feelings and reactions, reduce their sense of isolation, and improve their quality of life.[2]

Preventative Measures

I support the Older Women's League's position on the Senate Special Committee on Aging recommendations with respect to the expansion of home and community based care, the need for incorporating procedural safeguards in guardianship proceedings, and the proposed amendment to the Older Americans Act that would give the ombudsman discretion in reporting abuse to avoid jeopardizing the victim. However, I question the recommendation that the scope of authority of the Medicaid Fraud Units be extended to cover individuals in the community who are receiving Medicaid reimbursed home and community based services. This responsibility should remain with the adult protective service system.

Funding

In the past few years, some states have seen the APS share of Title XX Block Grant wiped out completely (e.g., Louisiana, Idaho) or reduced at the same time that awareness and reporting of elder abuse are increasing. The record of the Social Service Block Grant as the primary financial support of adult protective services is rather dismal. Most states that depend only on the SSBG have experienced not only a loss in funds but also a reduction in the value of the funds. Additionally, adult protective services are in competition with the child protective services at a time when reporting of both child and elder abuse is increasing. It is obvious that the block grant methodology has worked to the detriment of providing adequate adult protective services. I am in agreement with the recommendation that a specific percentage of the SSBG funds be allocated for adult protective services.

System Coordination

In addition to points covered in the OWL's Call to Action, I would like to urge the development of community coalitions on elder abuse. Elder abuse cases often present with multiple and intractable problems that are beyond the skill of a single or a few professionals and the resources of one or even several agencies to resolve. Some communities have responded by developing interagency groups (e.g., coalitions, consortia, task forces, councils, etc.), multidisciplinary teams or joint program initiatives (e.g., APS case worker-mental health worker assessment teams). Such efforts offer more options for treating abuse cases, improve communication, enhance chances to obtain new services, increase the likelihood of acquiring voluntary and in-kind support, and identify new community resources. These undertakings, however, need financial support for development, operation, and evaluation.

I thank you for the opportunity to participate in this round table discussion.

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[2] Wolf, R.S. & Pillemer, K. (1994). What's new in elder abuse programming? Four Bright Ideas. *The Gerontologist, 34*(1), 126-129.

Ms. ARAVANIS. Okay. Thank you, Rosalie.

And our last panelist here is Lori Stiegel. Lori comes to us from the American Bar Association where she is Associate Director of the Commission on Legal Problems of the Elderly. Lori has been one of those very effective, as Pat calls them, "pollinators." She has been very effective in helping the whole legal assistance network, the private attorneys, the pro bono attorneys, and public interest attorneys across the country to understand all of the issues from an older person's perspective, all of the legal issues, and trying to make improvements in that arena.

Lori, if you would give us your perspective on an issue?

STATEMENT OF LORI STIEGEL, ESQ., ASSOCIATE STAFF DIRECTOR, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION, WASHINGTON, DC

Ms. STIEGEL. Thank you, Sara.

Again, I also want to thank OWL and the Aging Committee for the opportunity to be here today and for making the effort to bring all of us together. It's always wonderful to come and meet each other, hear new terms, and learn what "midlife women" means, learn what an RO1 is, and now to learn about "pollinators."

The ABA is the Nation's largest organization representing lawyers and has a variety of policies that relate to the issues that we're talking about today, although unfortunately you won't find the words "elder abuse" among them. That is something that we will have to work on changing.

However, some related policies are improving the administration of justice and the legal system; condemning violent crime; combating family violence, and enhancing due process in guardianship proceedings. These are related to the recommendations that are in your call for action, and we are delighted to see those and we hope to help get those through.

Also, to get a little more specific, we currently have a grant from the State Justice Institute that is allowing us to study elder abuse and how it relates to the State courts, both civilly and criminally, and from that grant in about a year or so will come recommendations on how the State courts can better handle elder abuse cases.

With that background, you can imagine that the issues that particularly delighted me in this paper were those relating to the courts and the laws; again, more specifically, the recommendations regarding statutory definitions; all of those related to reporting, particularly mandatory reporting. I'm not saying that I'm supporting all of these, but I'm glad to see the dialogue brought further on these issues.

Enactment of Federal legislation on guardianship and elder abuse are issues that need to be discussed much further, and judicial training and judicial involvement in these issues and linkages between the courts and the communities, service providers, advocacy groups, and others are all critical issues. We hope that when our study recommendations come out in a year or so that they will lend some research support to these issues that we know anecdotally need to be addressed.

[The prepared statement of Ms. Stiegel follows:]

Comments of

LORI A. STIEGEL, ASSOCIATE STAFF DIRECTOR
COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY

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Mr. Chairman and Members of the Committee:

On behalf of the American Bar Association (ABA) Commission on Legal Problems of the Elderly, thank you for the opportunity to provide comments on the Older Women's League (OWL) Report on Elder Abuse and Violence Against Midlife and Older Women. I am delighted to join my respected colleagues at today's roundtable, and want to express my appreciation to the staff of OWL and the Special Committee on Aging for organizing this event. OWL is to be commended for its effort in developing these thought-provoking recommendations. I do want to note that unless I specifically state otherwise, the views I express are my own and not those of the ABA.

One of the world's largest voluntary professional organizations, and a representative of the legal profession in the United States, the ABA has long been concerned with equal access to justice for the disenfranchised, the elderly, and the disabled -- those members of our society who are generally least able to protect their own rights. The Commission on Legal Problems of the Elderly was created in 1978 by the ABA Board of Governors to analyze and respond to law-related needs of older Americans. One of the Commission's goals is to protect the rights of older persons by helping to prevent them from becoming victims of elder abuse or helping them to redress abuse.

The ABA House of Delegates has adopted three policies relevant to the issue of elder abuse and the recommendations developed by OWL.

The first policy, adopted in 1978, supports federal, state and local efforts to combat family violence, and recommends the adoption of certain procedures by the police, prosecution and the courts to make the criminal justice system more responsive to the problem.

In the second, adopted in 1987, the ABA condemns crimes of violence including those based on bias or prejudice against the victim's race, religion, sexual orientation or minority status, and urges vigorous efforts by federal, state and local officials to prosecute the perpetrators and to focus public attention on the problem.

In 1991, the ABA adopted a third policy that supports efforts to make the state and territorial judicial systems more responsive to the needs of the elderly and persons with disabilities.

The Commission on Legal Problems of the Elderly, with funding from the State Justice Institute and the ABA Fund for Justice and Education, is currently conducting a project that will result in the development of recommendations on how state courts can better handle elder abuse cases. The Commission has long been involved with efforts to improve guardianship laws and practice, and to enhance recognition of individual autonomy.

Research and Data Collection

OWL recommends mandated research on abuse and violence against midlife and older women. While research is important, there also must be a commitment to meeting the needs indicated by the research and by provider experience. Funding is necessary for the provision of a wide range of services and for public and professional education on elder abuse and the means of preventing and addressing it.

With the Commission's current research project as one of the first steps, research must continue looking at the ways in which the legal and judicial systems respond to different types of violence and elder abuse against midlife and older women. Are there different responses depending on the type of violence? Does the response differ depending on whether the abuse occurred in the community or in a health or long term care facility? Are there differences in the treatment of physical abuse and financial abuse? How important is the age of the victim (e.g., is violence against midlife women treated differently than violence against older women)? Or is the important factor vulnerability, rather than age (there is no consensus among the aging network about how vulnerable persons are to be treated and served)?

OWL supports research about the barriers that prevent older women from seeking and receiving help and the role(s) that ethnicity and race play in perceiving violence and obtaining services. These are important issues, but there are other matters that should be examined first. For example, are older women and women of varying ethnic backgrounds and races receiving assistance from outside the traditional aging, protective services, or domestic violence networks? What is the role of religious institutions, community organizations, community leaders, family, friends, etc. in addressing these problems for differing groups of older women? How can these entities best be linked with the traditional aging, protective services, or domestic violence networks so that victims of abuse can seek help where they feel most comfortable and resources are not duplicated?

Reporting

OWL's recommendations seem to raise 3 issues -- (1) mandatory reporting of abuse to a state entity, (2) consistent definitions of elder abuse among states, and (3) mandatory reporting by states to a federal entity.

(1) Mandatory reporting of elder abuse raises civil rights issues. Unlike children, older persons are presumed to have capacity unless a court determines otherwise. An older person who has not been adjudicated incapacitated has the prerogative to refuse consent to disclosure, reporting of abuse, or services. Mandatory reporting may discourage elder abuse victims from obtaining needed treatment or services.

(2) Developing consistent definitions of elder abuse among states would be an extraordinarily difficult task, both substantively and politically, although it might be useful for documenting the extent of elder abuse. The Commission's research has shown that states have a variety of criminal and civil statutes that relate to elder abuse in addition to their elder abuse or adult protective services statutes. There is no such thing as a uniform law in the United States; even uniform laws promulgated by the National Council of Commissioners on Uniform State Laws are, if adopted by a state, revised to reflect the state's priorities and political situation. Enactment of federal legislation on elder abuse may raise issues of constitutional law; it certainly raises the issue of funding (would the carrot or the stick be used?).

(3) To what federal entity would states mandatorily report elder abuse? Elder abuse is not strictly an aging issue – it encompasses issues of crime, fraud, institutional abuse and neglect, etc. Therefore, agencies interested in these reports could include the Administration on Aging, other entities in Health and Human Services, and the Department of Justice. Other possibilities include some non-government entity under a grant or contract from a government agency? But then what is done with the information? With whom or what is it shared? What about issues of confidentiality?

Policy Reform and Implementation

The recommendation that age be included among the protected categories identified in any state or federal hate crime legislation raises two issues for consideration. (1) Age is not always obvious and thus a defense strategy would be to claim the alleged criminal had no knowledge of the victim's age and no intent to commit a hate crime. If defendants are acquitted or receive a lesser sentence based on that defense, including age in hate crimes may be at best pointless and at worst counter-productive. (2) Including age in hate crimes equates age with vulnerability, disability, and other factors and might be viewed as ageist. The Commission and other aging advocacy groups have worked hard to remove "old age" alone as a basis for decisions relating to matters such as guardianship and employment and might be concerned about the precedent set by defining violence against an older person as a hate crime.

OWL supports implementation of the Violence Reduction Training Act, which calls for training of health care providers to identify and refer victims of domestic violence and sexual assault, with additional funding for training on recognition of elder abuse. Older persons have a great deal of contact with health care providers and elder abuse victims could be greatly helped if health care providers were better trained to identify abuse and refer victims to appropriate services and sources of help. Health care providers to be trained under the Act should include home health care and hospice workers. Health care providers can and should be trained about financial abuse as well as sexual assault and physical violence. Financial abuse may manifest itself with physical symptoms that health care providers can recognize – e.g. an older person may not be eating or taking medications properly because her income has been stolen by a family member or caregiver, or an elder might suffer from hypothermia because she cannot afford to heat her house as a result of financial abuse.

Establishment of a Coordinating Commission on Violence comprised of the Secretaries of the Departments of Justice, HHS, Labor, and Housing, other Cabinet departments, the director of the National Institutes on Health, and the Equal Employment Opportunity Commissioner makes sense; a broad-based governmental approach is necessary to address domestic violence and elder abuse. Research and funding efforts could be better coordinated to both avoid duplication and build on results of earlier studies and programs. Conflicting policies and procedures could be reduced or eliminated. A coordinated and wide range of services and options will benefit abuse victims.

Development and implementation by the Department of Housing and Urban Development of a policy of priority admittance in public housing for older abused women might make it easier for a victim of family abuse to leave the situation. However, we should look at whether the policy puts the burden and blame on the victim, rather than the abuser. The ABA has extensively studied the issues related to removal of child abuse victims from their homes and guardians and has addressed issues regarding foster care before Congressional Committees and through publications of the ABA Center on Children and the Law. Just as the ABA Center on Children and the Law has concluded that removal of the child often further victimizes that child and should not be the only option, the same conclusion might be reached regarding victims of elder abuse. Greater consideration should be given to

removing the abuser rather than the victim or enabling both to remain but with counseling, services, and oversight (assuming the victim consents, of course). The key to making OWL's proposed policy work for elder abuse victims would be to make it one of a number of options, so that those who want to leave could do so more readily.

Preventative Measures

OWL supports the enactment of federal legislation that would require states "to incorporate procedural safeguards in guardianship proceedings and to ensure that guardians are trained and accountable to the courts." The ABA has taken no position on federal guardianship legislation. ABA entities, including the Commission on Legal Problems of the Elderly and the Commission on Mental and Physical Disability Law, have worked for more than a decade to enhance due process protection in state guardianship laws. Both Commissions are currently working with the National Council of Commissioners on Uniform State Laws to amend the Uniform Guardianship and Protective Proceedings Act to incorporate more due process protection. Federal guardianship legislation is a controversial issue that raises complex issues of civil and state rights.

Aging advocates and various entities within the Bar have widely divergent opinions on the merits of federal guardianship legislation. Nevertheless, at a roundtable discussion on guardianship conducted by the U.S. Senate Special Committee on Aging in 1992, there seemed to be consensus among the participants that if there were to be federal guardianship legislation, it should not contain penalties that would harm the people who are the intended beneficiaries of guardianship reform. To illustrate, the guardianship legislation introduced by Representative Claude Pepper in 1989 proposed that if states did not comply with provisions of the law, then the "Attorney General shall, after notifying the State, withhold any payments or portions of payments to be made to the State under Federal law for administrative costs relating to the provision of services or amounts to be paid to elderly and disabled persons" (H.R. 1702, 101st Congress, 1st Session, April 5, 1989). Advocates agreed that limiting the penalties to administrative funds would not prevent older and disabled persons from being harmed and that financial incentives would be preferable to penalties.

Education and Training

All education and training efforts related to elder abuse, whether of police, judges, service providers, medical professionals, bank personnel, the public, etc., must incorporate information pertaining to individual autonomy, assessment of capacity, and guardianship and its less restrictive alternatives.

Prosecutors and judges, not just police and bank personnel, need training to increase awareness of financial fraud committed against older women. As financial abuse has played second fiddle to physical abuse for years, many protective services workers and social service providers also could benefit from this training.

Regarding OWL's recommendation that police departments and attorney's general offices earmark funds for public education on these issues, it should be noted that a number of attorneys general have created excellent public education campaigns on elder abuse. Existing campaigns could be shared with other offices as examples of what can be done.

Empowerment

Midlife and older women and the numerous professionals who deal with them also need education about the legal mechanisms that can assist with decisionmaking about health and financial issues if they become unable to make or implement those decisions themselves. Planning for incapacity might lessen the risk that an abusive family member or caregiver would make decisions contrary to the wishes of the older person or, if those wishes are unclear, her best interests. However, the greatest empowerment of midlife and older abused women would derive from expanded services and programs that allow an abused woman to exercise a real choice about how to deal with an abusive situation. All the research, training, and recognition of elder abuse are pointless if an abuse victim has no good options.

Legal and Judicial Reform

The ABA's Steering Committee on the Unmet Legal Needs of Children and Their Families has developed for consideration by the ABA House of Delegates in August 1994 a recommendation proposing that the ABA endorse the concept of unified children and family courts. As currently drafted, the family court jurisdiction would encompass "domestic violence including protective orders," "persons and children in need of services," and "adult and juvenile guardianships and conservatorships." Some of the reasons for development of family courts include enhanced expertise among the judges and the linkage with social services. Integrated information management is another benefit. Thus, this proposal is consistent with OWL's recommendations regarding judicial expertise and elder abuse case tracking and management. I will let you know what action the House of Delegates takes on this recommendation.

Elder abuse cases are often not recognized or treated as such, but instead end up in probate court or whatever court has jurisdiction over guardianship matters. A probate judge who hears guardianship cases has advised the Commission that there is so little communication among the various divisions of his county's court that he has no way of knowing whether the proposed guardian is being tried for or has been convicted of elder abuse or other crimes. Increased coordination, or the development of family courts, could alleviate that type of problem.

As elected officials, prosecutors focus on those issues which society deems important. The public, policy makers, and politicians need to be educated on elder abuse so that they will demand that it is prosecuted more than it is currently.

Specific support for many of OWL's recommendations, as well as other pertinent recommendations, may come out of the Commission's Elder Abuse and the State Courts Project during the coming year.

Ms. ARAVANIS. Thank you very much. As you can see, we do have the experts at this table.

Our next phase is actually to go into some of the questions that OWL and the Committee wanted to hear your comments on. It is not by chance that we start out with definitional questions.

In focusing the paper, OWL focused on all forms of violence, and they began to use the terms violence, crime, and abuse rather interchangeably in the paper. They also tried to include all forms of the traditional abuse lexicon: physical abuse, sexual abuse, emotional abuse, psychological abuse, financial and material exploitation, neglect, and criminal behavior in this whole big, wide net of violence.

Do you share OWL's view about definition? What do we need to do around definition in order to help the cause of midlife and older women and violence to be more directed? Just give me a signal if you want to speak to that whole issue. Are we talking specifically enough in a definitional framework around these problems that we lump under the heading of "violence, abuse, and crime"?

Rosalie.

Dr. WOLF. A study was done on definitions by Dr. Margaret Hudson of the University of North Carolina School of Nursing. She was particularly interested in developing a typology for elder abuse, using the Adelphi methodology, which is the procedure being used in the ABA study, she asked experts their opinion until she reached a consensus. From the procedure emerged violence against the elderly as the overarching concept for elder abuse.

Although at first I thought violence was perhaps not quite the word, I now believe that it may be a good choice because it allows for elder abuse to fit within the family violence and violence constructs.

Dr. FULMER. Sara, I would just second that and say that violence is something that the American public understands and can get behind. We are at a critical point in our history in coping with it, and I second Rosalie totally.

I think that the way in which we operationalize our studies is really secondary to catching attention.

Ms. ARAVANIS. Go ahead, Toshio.

Dr. TATARA. It is true that existing data show the family is, in fact, a violent institution. However, when you look at the elder abuse statistics closely, neglect accounts for the majority of the cases that are reported or substantiated. More importantly, though, self-neglect—which you may argue about whether it is a violent act in itself or not—nonetheless, self-neglect also accounts for a considerable portion of the reported cases, as well as of the substantiated cases. To say that elder abuse is violence is something that we need to discuss. I have great reservation in that direction; that is to say, that all forms of "family violence" are in fact violence.

So I would like to discuss this further.

Ms. ARAVANIS. Let me ask a clarifying question here. Do all of the domestic violence people know what we're talking about when we say "self-neglect"? Sometimes that's a confusing term to some people.

Dr. FULMER. I would worry if we got off on that in the very precious time that we have.

Ms. ARAVANIS. Okay, I hear your comment.
Yes.

Ms. REUSS. Like my ABA sister, I want to talk about crime without having a specific opinion on it, except that I wanted to ask us to put together both violence and crime. In my original statement I said it is such a private activity, whether it's ourselves or people close to us. We know that when the bogeyman or bogeywoman jumps out of the alley, beats us up, blood, broken bones, that's a violent crime, and that's only about 10 percent of the violent crimes that occur in this Nation with strangers. The rest of it is in our homes or our schools or wherever.

So maybe to be dramatic, which I think we have to be, I want us to consider—until talked out of it—that that's how we're going to educate the judges, that's how we're going to educate the people, and that's how we're going to write the laws. When we wrote the Violence Against Women Act, we called it a violent crime. We're going to get in the Hate Crimes Act, and right now there is consideration of hate crimes being put into the crime bill, or at least down the road.

So let's see how that feels, and by the end that might be what we recommend.

Ms. ARAVANIS. Elma, let me go to Handy first, and then I'll come to you.

Handy, go ahead.

Mr. BRANDENBURG. I want to second what Toshio said about the importance from the Adult Protective Services perspective of self-neglect as a part of the risk to elderly, as well as nonelderly individuals, which many if not all States have recognized as a matter with which they want to deal. Whether or not it fits in real neatly with all of the other things we're talking about, I think that it is in fact a fact of life for the people who are dealing with the more typical abuse and neglect and other things that perhaps are more easily definable in our discussion of violence.

The other thing that I wanted to say is that from the perspective of Adult Protective Services Administrators, I think one of the things that we're beginning to see—and I don't know that it's being reported more or is happening more—but a growth in the concern about sexual abuse among the Adult Protective Services population. Maybe we need to talk a little bit, too, as we define things, about what populations we are talking about. In my conversations with people in the women's violence/domestic violence area, typically they have talked about the more well as opposed to the more disabled, whereas in Adult Protective Services we are typically talking about vulnerable adults or people who lack capacities. I think maybe that needs to come as part of what gets defined, too.

Ms. ARAVANIS. Lori, I'm over to Elma first.
Go ahead, Elma.

Ms. HOLDER. Let me just take us back to the institutional setting. One of the very complicated issues in relation to nursing home care is people's inability to focus on neglect and poor care early enough so that it makes a difference. It seems in our enforcement system something has to become very abusive and so overtly bad for a person before we will even talk about it or bring it to some kind of justice.

So I would just urge us to continue to think about how we can get people to think about neglect in a serious way, because in my mind, particularly with a vulnerable elderly person in an institution with all their illnesses and frailties, that poor care, poor care, poor care becomes neglect, neglect, neglect; and then neglect, neglect, neglect, becomes abuse, abuse, abuse. In some people's minds, and this has even been brought out in one lawsuit in Texas years ago, is that actually murder—if you go all the way, if you neglect a person who is so vulnerable in the first place, for so long and they die unnecessarily, what do we call it? I think there is definitely a real reluctance on the part of the licensure and certification community to really address seriously the issue of neglect in institutions. So I would just call for us to really think about that carefully.

Ms. ARAVANIS. Lori, you had something you wanted to say.

Ms. STIEGEL. My concern about the use of the term "violence" is that it really excludes all of the financial exploitation issues, as well as the psychological and emotional abuse issues that I know Tom has dealt with, and which I hope he will address somewhat.

It seems that financial exploitation is only now, after the 10 years or more that we've even been talking about elder abuse, starting to be recognized as a problem, and lawyers and Protective Services workers and others are beginning to recognize it and to address it through litigation and through public education and professional education and other means. If it has taken it this long to come around just using the term "elder abuse," I can imagine that it will just get totally subsumed again if we focus on the word "violence" and the implications that come from that.

Ms. ARAVANIS. Tom, I knew you would have something to say here.

Mr. CARLUCCIO. As long as all the terms can be explained under the word "violence," again, that is a really good attention-getting device. But in my State, "neglect" can be associated with serious physical injury and death that we investigate in many cases. So neglect can be almost a violent crime, or should be considered a violent crime. At least, that's one of my recommendations.

But with the evolution of crime in this area, especially mistreatment—Delaware law defines mistreatment as including the inappropriate use of medications, isolations, or restraints. I prosecuted my first case after 5 years for restraints. Without good definitions and research, we cannot find out what the problem is. The definitions, if we include everything under physical abuse or violence, we're not going to know that restraints should be a criminal act.

So I'm a little scared to term everything "violence" because of the fact that we really have to put through each definition and what it is, because now I want to know how much mistreatment or illegal/inappropriate use of restraints there are, so that I can sell that to my legislature and get resources to prosecute that type of crime. So the definitions are very important.

Once we get the definitions, somebody has to go out there on the street and say, "What is mistreatment? What is neglect? It is lack of attention to physical needs." Some people think neglect is when somebody dies because somebody wasn't fed enough nutrition, but it's also toileting, safety, it's all sorts of things that could be neglect

that leads to someone's death. So the definition is not only getting them down on paper, but actually getting people to understand what they mean. My problem with juries is that I must spend a half hour just explaining what neglect means. I look at their heads, and they're still going this way [indicating]. This is after being on the streets.

Ms. ARAVANIS. Joan, you had something you wanted to add?

Ms. KURIANSKY. In the Older Women's League we struggled ourselves, in how to define this particular Mother's Day report. In suggesting this was an issue of violence against midlife and older women, we wanted to speak to many of the underlying reasons why older women disproportionately are victimized by violence. We wanted to make the connection to younger women, who are battered, and may continue to be battered as older women. We wanted to make clear that this is an issue that has a lot to do with women's role in society. If you look at the percentages of women, whether in institutions, on the streets or at home, who are in some way abused, they are abused at a rate significantly higher than the percentage of the population as a whole.

It is important to acknowledge the role of many women and elderly people as we define the problems of abuse and look for solutions.

Dr. FULMER. Sara.

Ms. ARAVANIS. Yes, go ahead, Terry.

Dr. FULMER. Quickly, I think that this harkens back to the issue of a minimum data set. My experience is that you get what you ask for. I had a VOCA-funded research project in which we asked about abuse and neglect, but also violent crime. As an example, a woman came into the emergency room with a head laceration. When we read the chart the next day it said, "4.0 silk, stitched, Tylenol, sent home." We called them the next day and said, "How did you get that?" She said, "My son hit me with a brick."

If we hadn't been looking for that and asking, we wouldn't have known.

I think that you're right. We need very specific areas, and then we can begin to glean across groups and geographic regions for the prevalence and sequelae.

Ms. ARAVANIS. Elma, did you have a follow-up comment?

Ms. HOLDER. I think it's important to point out that in the survey and certification process with nursing homes, that at least in the Federal law and regulations there's nothing that guides a survey person to check off neglect. Everything is couched in terms of quality of care, residents' rights, nursing services, medical services. So when you go to HCFA and you ask them about how much neglect and abuse is in facilities, abuse is rarely cited because they practically have to prove it in court before they cite it as a deficiency.

But neglect doesn't show up at all in statistics for nursing homes, even though it shows up in these other areas, and you have no clear definition at all.

Dr. FULMER. Would you say that that is also mixed in with malpractice? That's been my worry about neglect; for instance, nursing malpractice.

Ms. ARAVANIS. Tom, could I follow up that one with you? In any of the cases that you have prosecuted of people in long-term care facilities, has the survey data been at all used by you as evidence one way or the other for quality of care or lack thereof?

Mr. CARLUCCIO. No, but the surveys themselves, yes. Again, it's just beginning to start to happen. We have some prosecutions coming up with nursing homes, and they are my witnesses. There will be documents that will be entered into evidence. So it is very important that their definitions be the same as other people's; or individuals have the same interpretation.

Ms. ARAVANIS. Okay.

We have a couple of questions from the audience. Would you stand at the microphone and also introduce yourselves, please?

DWAYNE REAGAN, OFFICE OF VICTIMS OF CRIME

Mr. REAGAN. I am Dwayne Reagan with the Office of Victims of Crime. We have several things that you have talked about today; I was glad to hear that VOCA funds are being used wisely.

But we have done something else that I also heard, one on bias and one on elderly abuse. Maybe you're aware, and a lot of you are, that a year ago this last October we had a National Conference on Elder Abuse. We tried to have one again this year, but as you know, things are changing a little bit. We have all acting directors in our bureaus. I think we will get settled down before long and have some more things like that.

But I do have two sets of curricula materials that are really very excellent materials. One is on bias and hate crimes, done by the Education Development Center in Newton, Massachusetts. The other was done by the Police Executive Research Forum here in this area, and that's on elder abuse. Those are available through my office, and if you would like to have copies of those and you would give me your name or call me, I would be glad to let you have those.

Ms. ARAVANIS. Thank you, Dwayne.

Another question over here. Would you mind going to the microphone, please?

KAREL CORNWELL, ACTING CHIEF, ADULT PROTECTIVE SERVICES, WASHINGTON, DC

Ms. CORNWELL. Hi. I'm Karel Cornwell. I'm Acting Chief of Adult Protective Services here in the District of Columbia.

When we're looking at definitions, we really need to go back. Some of the laws have been on the books for a long time and conditions and understandings have changed. Our law calls for "repeated infliction of injury," so the first time is free. We don't take that into account. We will investigate at any juncture that a crime like this is reported to us, but I think it's time to go back and look at laws.

A second factor is damages against perpetrators. There is none written into our law, and I suspect that's true across the board in a great many States. They can thereby utilize the victim's funds that they exploited to defend against you. These are not attractive cases for lawyers in private action because there is no guarantee of recovery. There is no way to get restitution unless it's through

judicial discretion, and though we've always been very successful on getting rescissions of property that has been deeded over to people, but far less successful in getting money back that was taken, even where the person had that ability.

So we are now in the process, with AARP's legal counsel for the elderly, of looking at the law in the District and planning to make some changes in this regard, following the California statute which is really excellent.

Another thing is in terms of sheltering people. We were just recently successful for the first time on an ex parte basis in getting a judge to evict two drug-addicted sons who had beaten their stepfather and attacked their natural mother for money.

One of the problems, even with good Adult Protective Services laws, is that when you get into court with a judge, they often want a full hearing with all parties, and that takes time, especially if your law requires notice. So the chances of getting a perpetrator out of the house immediately declines. I think that's why it's frequently a matter of taking the abused person out. There you encounter another problem, at least we do, here; lots of times shelters for abused elderly have, of course, age requirements because of their funding, and yet one of the worst abuse cases—a woman who was burned on her back and on her legs—as we began to investigate we discovered that she had had a number of broken bones and was treated at various hospitals in the past. We could not have removed this woman from her home. Fortunately, we didn't have to, but we couldn't have removed her because she was 52 years old and would not have qualified to go to one of the shelters for abused elderly, for which you have to be 60 or older.

Handicapped accessibility is another problem, and this really needs to be addressed. We have an excellent shelter here, a dwelling place, for abused elderly, but you need to be able to negotiate stairs to the second floor.

So there are a number of areas that really need to be looked at and addressed. I hope that we will be able to look across categories, because that is one of the things that prevents funding and becomes a barrier in itself to helping these vulnerable populations.

Thank you.

Ms. ARAVANIS. Thank you very much.

I'm going to turn the microphone over for a minute to Lou Glasse for an important introduction.

Ms. GLASSE. Actually, he's our host.

So if we might introduce Senator Pryor, who is cosponsoring this event—you're on the run? Okay, well, let me say that we are very pleased that you have cosponsored this roundtable with OWL. We really want to commend you for your leadership as Chair of the Senate Committee on Aging. This morning you told us that early in your Congressional career, you learned what happened to older people in nursing homes. We are delighted you are here and wish to turn over the Chair to you, sir.

STATEMENT OF SENATOR DAVID PRYOR, CHAIRMAN

Senator PRYOR. Well, I wasn't going to talk about that, but many years ago—some 25 years or more—I was elected to the U.S. House of Representatives. One weekend I was home visting and my moth-

er who had just put one of her great-aunts in a local nursing home in southern Arkansas. She told me about all the horrible conditions in the nursing home. The food was awful, there were roaches, and it was unbearably hot in the room in the summer. So I said, "Oh, mother, that couldn't really happen in our country; we have all these regulations and what have you." So she said, "Well, why don't you go out there to the nursing home with me, big boy?" I said, "Okay." So we went out to the home, and it was worse than she had said.

So I came back and got about 15 people in a room—the Veterans Administration, HUD, HHS, the old HEW, and I said, "Let me describe what I saw in a nursing home and I want to know if this is the exception or if this is the rule." And the honest collective opinion of the group was that the conditions I described were the rule; not the exception but the rule. So I said, "Well, I'm going to go find out." So I went out and I became an orderly in 12 nursing homes. I didn't let anybody pay me. I didn't tell them I was a Congressman. I did all kinds of things: I shaved people, emptied bedpans, and prepared the food trays. I also read to the residents, wrote letters for them, talked to them and observed how the nursing home was run.

I can tell you that a nursing home—and many of you have had experiences with your families—a nursing home, after the sun goes down, is a lot different than in the daylight. It's not as good, and it's especially not as good on the weekends, on Saturdays and Sundays when there is not enough help.

As I told the group this morning, we have a very strange anomaly in American law throughout the respective States. Most of the States have jurisdiction over this area, but not altogether. Today in most States, I think about 40 of the 50 States, there are no background checks required for nursing home attendants and orderlies. You can walk out of the State prison as a convicted murderer after you've served your time and you can get a job in a nursing home. You can be a rapist, and the next day you can get a job in a nursing home. This is a huge vacuum or void that I think we've really got to look at.

I am hoping that next year in the month of May, at the White House Conference on Aging, we can really take this unique opportunity to highlight these types of issues and these types of problems. In our press conference today, Senator Biden was so eloquent in talking about some of the personal concerns that he has encountered, and I know that some of our experts here today are going to be addressing this issue and have addressed it.

I want to thank those wonderful people—I've worked with Elma for years, and I have worked with many of you around this table for years on many of these issues. I just want to personally thank you for dedicating your lives and your resources and abilities to helping us grapple with the great and complex problems of growing old in America.

After the nursing home investigation, I worked to establish a Committee on Aging in the House of Representatives. We didn't have one then in the House. Ultimately, we had one and Claude Pepper became its Chairman. I had left the House by that time,

but Claude Pepper always used to say that I got him his first honest job. [Laughter.]

I don't know, he was always pretty neat in giving me credit for helping to get an Aging Committee started in the House. And do you know, it has now been abolished? There is no longer a House Aging Committee. It's been abolished. They tried to abolish the Senate Special Committee on Aging last year, and with the help of many of you in this room by contacting your Senators, we were able to save this Committee. We think it's a very good Committee. This Committee serves every Member of the Senate, regardless of party affiliation. We supply facts and figures and data. We supply data to the Senate Committee on Finance, and some of that data was used this morning in a hearing right across the hall on health care reform. The Special Committee on Aging does good work.

We've started to do more roundtable forums like this, rather than just doing formal hearings where witnesses come before us and give their testimony, because we like the fact that everyone can participate and be of the process rather than part just having to listen to two or three speakers going on and on. We like to mix it up a little bit and we think we get a little better flavor. So we have used the informality of these proceedings to further the cause and to further some of our objectives.

I just want to thank you. We are proud to be your host. We are certainly proud of the OWL group that has been so great in working out all the details of this forum. We had a good press conference this morning. Did you think it was good?

Ms. ARAVANIS. Yes, I did.

Senator PRYOR. We had the Attorney General. I don't have the strength to get the Attorney General, but I guess you did. [Laughter.]

We were very proud to have her here. We think it was a very good press conference.

We have to keep reminding people all the time of what this is all about. I know that we will, with your leadership, and we will cooperate in any way that we can.

Ms. GLASSE. Well, your voice in the Senate is so important for this country if we are to address the issues of all the people. We do thank you for that and look to you and to Senator Cohen for your continued leadership.

Senator PRYOR. Thank you very much, all of you. I appreciate it.

Ms. ARAVANIS. Well, it's great to have the policy people right here with us, and their ears and eyes still remain with us all the time.

I think we have sufficiently discussed the whole issue of definition. I'll tell you what I feel that we have said. I think we have said that the violence rubric is what we need to get attention, that we really need that in order to get the attention focused on the violence against older women, whatever it involves. As we are doing more research and more clarification of some of the problems under that heading of violence, that we then work to fit appropriate definitions under that heading. It is sometimes difficult with issues such as financial abuse and neglect, particularly self-neglect, but that we still try to use it. When we are talking about minimum

data sets and data items so that we can then we focus on specific and common definitions.

Let me move on to our second issue. In spite of the fact that OWL put out this whole list of data, we still have major gaps in the information sources that we need in order to justify more attention on this whole issue of violence and abuse against older women.

I would ask you, what key data do we need that we don't have? What kinds of information do we need in order to justify the case more effectively? Rosalie.

Dr. WOLF. We have learned from some of the research that the perpetrator's characteristics may be more predictive than the victim's characteristic. Yet we do not know much about perpetrators; often, the relationship to the victim, age, mental health and alcohol history. This lack of information is a big gap as far as trying to understand the dynamics intra family that result in violence and how, then, to prevent it.

Ms. ARAVANIS. Good point. Does anybody else want to add to that issue?

Go ahead, Tom.

Mr. CARLUCCIO. As Senator Pryor pointed out, I found that—we have a first offender program, and a lot of times in neglect and abuse of caretakers it can be used if you have no record. But many of the perpetrators do have records, and some of them are serious, such as manslaughter, murder, and prostitution. Learning more about the perpetrator or caretaker, what type of medical background, if they have any medical history—a lot of them have been committed to a State hospital at some time—so people are being hired as caretakers with records and mental problems, so therefore learning more about the perpetrator might help.

Ms. ARAVANIS. Elma.

Ms. HOLDER. The State Abuse Registries that are now required under the nursing home reform law could, I think, lend themselves to some really good information. We know we can get the names of people on those abuse registries, but we can do some research to determine how much information is available, and then it would be great to have some kind of special research where some research person goes in and really tries to do some analysis of the interviews with the people who are on the registry, just to try to get a real understanding of where these people are coming from and what they think was the reason for the abuse and neglect, particularly if you have strong findings against them.

Ms. ARAVANIS. Pat, did you want to say something?

Ms. REUSS. Let me speak for my sisters or other victims of abuse who are used to not having their voices heard, whether it's their race or their religion or some other class where there are victims for many reasons.

No matter how hard we work and how good we are at collecting the data, we are only going to get anywhere from one-fifth to one-half of it because women aren't going to tell, because when we tell, we aren't believed. Even those of us who have voices, loud and clear, and aren't silent by reason of age or infirmity, need advocates.

You said that juries are sometimes more supportive than judges and law enforcement officers are. In cases of violence against

women, sexual assault and domestic violence, juries are as bad, if not worse, because juries—anyone who hasn't been themselves a victim of sexual assault, sexual harassment, any of the gender-related activities, many of those women—and most of them are men—can't understand why—and you know this; we watched it on Anita Hill. We had a national teach-in—why didn't you leave?

And yet with elder abuse, we understand—when you said that those women want to stay in their homes, I said, "Oh, absolutely." Then how come it isn't all right for the 16-year-old to not be able to stay in her home, and the 17-year-old boyfriend to leave, or the 23-year-old, or the 43-year-old? Why did she have to take the three kids and go to the shelter?

But they aren't going to tell, so you won't be able to collect the statistics. We're going to lie to the doctors: "It was the doorway," for the 37th time. Part of it is shame. Part of it is our own acceptance of the blame, and the only time these women are going to tell is when the community and the State and the Nation and OWL and the advocates and the doctors and lawyers say, "It's our problem. It is not the problem of that victim." And when we say it's a community problem and there's no excuse, and we are going to take responsibility, then I can say, "That happened to me," whether it was financial fraud or whatever. When there's a flood, nobody is embarrassed to report that our house got flooded away, but when we're victims of another kind of a disaster, where people won't believe us, we're silent.

So all the data collection won't do it until we help those women and men, and especially the elderly, to come forward.

Ms. ARAVANIS. Go ahead, Handy.

Mr. BRANDENBURG. I think I'm beginning to see a bit of a backlash around the area of information about perpetrators in the State of Maryland. I've seen it with child abuse, and I've seen it to some extent with adult abuse. There is some resistance to maintaining information about perpetrators. It's kind of like the mindset is that we're keeping information about innocent people and giving it out to anybody who would ask for it, when in fact our confidentiality laws are very strict; they leave control of who gets to know what's in that record, basically, with the person who was the alleged abused or neglected person. I'm talking now primarily about domestic settings, outside of institutions.

I think we also are seeing this, though, in the fact that Maryland is having difficulty getting the State enabling legislation to have the kind of State Abuse Registry that was referred to earlier.

So I think this really is a serious public policy and public education issue that has further implications that maybe need to be thought out.

Ms. ARAVANIS. Go ahead, Lori.

Ms. STIEGEL. I guess I want to go off slightly on a tangent that has been prompted by the mention of the State Abuse Registries, and by Senator Pryor's comment about how easy it is, when you get out of prison as a rapist or murderer, to be promptly hired.

The State Abuse Registries will be good at dealing with that within the State, but not in dealing with the problem of when people cross State lines. I think it would be very appropriate for the Senate Aging Committee and OWL and other national groups to

look at and start talking about the issue of a National Abuse Registry, because we're an awfully mobile society.

Ms. ARAVANIS. Go ahead, Terry.

Dr. FULMER. When you talk about data needed, two points.

I think, number one, that every health record in this country should have an abuse history, meaning, is there any family violence in your home? That may sound silly, but just as 20 years ago, we didn't ask a sexual history. We can ask a family violence history question, just one. If the American Medical Association and the American Nurses Association got behind that, it could change people's opportunity, which I think you're speaking to. They will still be silent, but maybe we will get tips.

The second point is that we must collect data on demented elderly. Fifty percent of nursing home residents have a dementia of one sort or another, and those are people who cannot speak for themselves. We have to understand how we will get data about abuse and neglect and victimization of those individuals. Some of us are trying hard to do that.

Part two of that is that because you are cognitively declining, that does not equate to dementia; and people with cognitive impairment can still speak to their own rights and do not necessarily need to get thrown into guardianship or conservatorship or whatever.

Ms. ARAVANIS. Does anybody else have any comments on this whole issue of data?

Go ahead, Toshio.

Dr. TATARA. I hope we are not building a design for an information system on these issues that we are talking about. These are very complex tasks. What kinds of data are needed depends on what we need to do with or want to do with the problem that we address. So it is a difficult question.

However, on the whole, dealing with elder abuse or any other programs like that, we need to know more about the victims, very clearly. We need to know more about the perpetrators or abusers, clearly. And also, the unique thing about elder abuse is that someone is reporting to a report-receiving agency. We would like to know the reporters of elder abuse, or be it child abuse or any other types of "family violence."

We would like to know more about the services, particularly what kinds of services are available, and what are the outcomes of these services. Whether we know their effectiveness or not, the services are provided and the expenditures are spent; then we want to know about the expenditures. How much the type of services that are available would cost, and how effective they are, and so on and so forth. There are a lot of things that we would like to know, and those data are not available.

Once again, though, resources to create the information systems are limited, and therefore a very thoughtful process is needed to develop a design of information systems, such as elder abuse or any other types of family violence.

Ms. ARAVANIS. Good. Thank you.

Handy, any more follow-up?

Mr. BRANDENBURG. Toshio talked about services that are available, their outcomes, and their costs. One of the things that would

also be of interest to me are those services that are necessary but aren't available.

Ms. ARAVANIS. Joan, you wanted to make a comment on that?

Ms. KURIANSKY. I think there's a balance that we have to strike, and it is complex. Where do reports take place? What is the potential danger to someone of having that report made? This is a dilemma whether you're talking about the protocol that was recently endorsed by the AMA, which allows for a list of questions being asked to determine whether someone is coming into the emergency room with a presenting problem that is rooted in violence, or you're talking about reporting information that comes through Protective Services. I am concerned that as we look at the issue of reporting we don't forget, A, the autonomy and the right of a woman if she does not want to have a report made; and B, the ability to maintain confidentiality to protect her so that she is neither retaliated against nor in some way further harmed? I think this is an issue that crosses both "Protective Services" and the other abuse issues.

Ms. REUSS. I have another report—I can't believe I forgot it; it's such a bad little secret that I forgot. Another reason that women soon will not be reporting being victims of domestic violence is that many health insurance, disability, and life insurance companies—there's a bureau in Massachusetts called the Medical Information Bureau—doctors report battering of any age, and then you have to be batter-free and victim-free for 7 years before you are then back into sort of a "normal person" status. In the meantime, you can be denied health insurance; your rates can be raised; a whole bunch of things can happen to you. So one of our favorite things to do at the NOW Legal Defense Fund is to take on insurance companies, and we take on everybody who has lots of money and are sexist; I can't believe I forgot about this.

But I do not want to go tell women to not report being battered, and to collude with the doctors and the hospitals so that they won't have their insurance dropped or raised. I mean, the insurance we know now is bad enough when you're just sort of an average middle-aged person like some of us. If you have this history of something wrong with you and you didn't leave, and it hasn't been 7 years, they treat you like a race car driver or some high-risk person.

Ms. ARAVANIS. I know Elma would say some things as well about that whole issue of fear of retaliation by people in care facilities. Maybe there are some things we can learn from the women's movement, NOW in particular, about protecting people who remain in vulnerable situations.

Let me move on to the next issue, which follows right on what we were talking about here, which some people already started to talk about. What areas of research need to be addressed? When we started talking about data and statistics, Rosalie, you talked about wanting to do more research on perpetrator characteristics. Elma talked about wanting to do more research around the use of State Abuse Registries and what they are telling us about the problem and the characteristics of people involved.

What other things would you add to your research agenda if you had the ability to add an issue or a study?

Dr. FULMER. Sara, we have no national data sets. We can't say anything about Pennsylvania that I could relate to in New York or Connecticut. We need a national data set.

I worked in Massachusetts for 12 years, Connecticut for 3, New York now for 4. I can't translate across those three little Northeastern States; God forbid I should try to have a discussion with my colleagues in Texas about what they're finding. I plead for national data sets, that we can get that done.

Ms. ARAVANIS. Go ahead.

Dr. WOLF. I think we need—and it was mentioned earlier—evaluation data. There are a lot of programs but we really do not know how effective they are.

We need to know more about the nature of the problems within the family? What are the intrafamily dynamics, that might lead adult children to abuse or neglect their parents? We need this information to be able to help with both prevention and treatment.

Another aspect of the problem that is just beginning to be addressed is the role of culture. Are there differences in awareness and definitions based on cultural values and traditions. We are beginning to learn that the individual's perception of a situation might be somewhat different than the professional's definition or the State's definition. How does this affect the ability to serve that person, to treat that person? We need to know a lot more about how older persons think about this problem, and the ways to prevent it.

We know very little, including how prevalent it is.

Ms. ARAVANIS. Any comments from the audience that you would like to make on the whole issue of research that you think is needed in this arena?

Please identify yourself before you make your recommendations.

JUDITH BOWMAN, AARP WOMEN'S INITIATIVE

Ms. BOWMAN. I am Judith Bowman with AARP's Women's Initiative.

First I would like to congratulate OWL on another smashing Mother's Day report and thank you both, Lou and Joan, and all of OWL for your ongoing efforts on behalf of midlife and older women. It really means a lot.

I just want to mention briefly a forum that AARP had in October 1992 on older battered women. Rosalie and Toshio participated; we brought together representatives from the elder abuse and domestic violence communities to explore the issues around older women abused by their spouses or partners.

There is a report available; I've left some forms out at the table.[1] If you want one, just fill it out and send it. In it are a series of recommendations, many of which are on research, so I will just refer all of you to that.

But I want to tell you about some good news. The AARP Andrus Foundation has just agreed to call for research on violence against older battered women. I don't have the calls, but anybody can contact me and I will let you know. Those of you who are researchers here, I thought, would be very interested in learning that. They

[1] See appendix for form, p. 180.

were very enthusiastic in recognizing the need for this kind of research. Whether we will get a national data base out of it or not, I don't know, but a lot of the points Toshio just made are things that could be examined under that funding. So I am happy to report that.

Ms. ARAVANIS. Okay. Thank you very much.

Frances, if you would introduce yourself?

FRANCES HICKS, AMERICAN UNIVERSITY

Ms. HICKS. Yes. My name is Frances Hicks, and I do research in this area at American University.

One of the big problems I find is that there's a whole path of elder abuse literature and research, and a whole path of domestic violence research and literature that deals with younger women. But to wed those two together has been very difficult. There are no data sets with numbers. One of the largest data sets in the country used by social scientists is the General Social Survey. It has been in existence for 21 years and there is not one question in there that will link the abusers with the abused. It skirts the whole issue. I think what's really lacking is something that investigates the power relationship in couples, because that's very crucial as to whether they report.

One of the things mentioned this morning by Senator Biden was that during civil action against abusers, while that's fine—that's fine if you can get an abused person who feels empowered enough to go and press charges against her abuser and suffer more abuse at the hands of the system. So we need research that connects up what happens in power relationships with older women.

Ms. ARAVANIS. Yes?

GRETEL WEISS, OWL BOARD

Ms. WEISS. I am Gretel Weiss from the OWL Board.

There has been mention here that we need data and research on how well intervention works, but I think we might have to go back a step and find out how much intervention takes place, or does it simply stop at the reporting stage? I have heard this quite often; people will say, "Yes, we have a report of abuse, but we don't have the funds to follow up adequately on correcting the situation." So I think we may need data on that, as well.

Ms. GLASSE. Sara, if I might?

Ms. ARAVANIS. Sure. Go ahead, Lou.

Ms. GLASSE. I was Director of the State Office for the Aging in New York in 1980 at the time that the first proposal was made within New York to enact a law to require mandatory reporting of elder abuse. The State Office for the Aging seriously looked at the problem. We were eager to gather data on this to better understand the severity of the problem. After working with the criminal justice system and with the Governor's office, we decided not to require mandatory reporting of elder abuse. We lacked the ability to assure the appropriate referral and to secure services.

We only have to look at our lack of success with child abuse to see the problem. Now, when we have a child abuse case, after being referred, the case goes onto the social worker's desk as an-

other case of maybe another hundred, 101, 102, 120. That social worker must solve the problem of child abuse.

If we expect the same sort of procedure which results in an older person returning to the place where the abuse occurred, and with the same lack of incapacity of our communities to respond to the problem, then we understand this terrible dilemma that we're facing. Either we come to grips with that inability of our communities to respond to the need, or else we must confront the fact that by enacting a bill and asking people to report an abuse, we are creating an impossible dilemma.

Ms. ARAVANIS. Thank you, Lou.

Would you introduce yourself, as well?

MARGARET FELDMAN, NATIONAL COUNCIL ON FAMILY RELATIONS

Ms. FELDMAN. I'm Margaret Feldman, of the National Council on Family Relations. My constituency are researchers, so I'm interested in a technical point, and this is addressed to Terry, as well. The question in your first statement, you say to disaggregate your data at least in terms of 10-year intervals. And I want to push for having the 10-year intervals defined consistently over time, so that it's 1990. And I would really like to go for 5 years. Because if you're interested in what's going to happen as a result of your efforts to diminish, or, you need to have consistent data so that you can go year by year and trace trends. So I'd like to suggest that.

Ms. ARAVANIS. Good. Thank you very much for your recommendation.

Tom, did you have a follow-up comment?

Mr. CARLUCCIO. Yes, something quickly.

Ms. ARAVANIS. You need to go into the microphone a little bit closer.

Mr. CARLUCCIO. It must be that being a trial attorney, I've never used a microphone. I walk around the courtroom.

Something that I've noticed is that from a criminal point of view that the civil remedies are not enough, maybe because we don't report. But I've found most abusers that come across my desk are repeat offenders. And they go from one nursing home to another. And unless there is a criminal prosecution, the civil remedies just aren't there. They will be documented, that this person in their file had abused a patient emotionally or physically. But most of the time, the most that happens is that they're fired. And what I find is that I will be prosecuting someone and finally convict that person, and they'll still be working in the nursing home, or working somewhere as a caretaker, so why is this person still in care until they're convicted criminally is beyond me.

So I believe there should be some research of why repeat offenders, at least allegations of abuse, in which case caretakers get fired, so there must be some basis for it, many times they get the jobs back, also. So there needs to be some research in the civil area, not all depending on criminal to weed out abusers.

Ms. ARAVANIS. Have people talked to you, Elma, about issues in that arena, about—people against whom there are allegations, against whom there is proof, but they are not prosecuted?

Ms. HOLDER. Well, there's a real concern for, in terms of the abuse registries, that we determine why people have a finding against them of abuse neglect, and one of the issues that we've dealt with in working on the reform law was we had the recognition early on that we were pretty much blaming the nursing assistants for everything that happened in facilities.

And so we began to recognize that there needed to be some look at, particularly in a nursing home situation, to determine whether or not management decisions actually are the reason for a lot of the neglect and abuse, whether that be short staffing, not employing enough staff, not training, not having enough supervisors, not having enough qualified supervisors, not having the supplies and equipment that you need. And I think the unions are very concerned, and rightly so, that people will be blamed for something that's beyond their control. If you're taking care of 25, 30 residents in a facility at a time, and something happens, you have an accident, someone gets dropped or something, you know, is that the person's fault that dropped the person or is it some management decision.

So we did revise the reform law to say that you would look at a situation to determine whether it was beyond the fault of the actual aide. But there are a lot of real concerns and we should pay real close attention to the due process rights of people in these abuse registries, and I think that too often we don't look deeply enough at the issues and why something occurs, particularly in the nursing home. And I think that's probably true for even home health care agencies, where often workers in home care situations are double shifting, because there's not enough staff. So that's some of the ways we've tried to address it.

Ms. ARAVANIS. Yes, Pat?

Ms. REUSS. I was rifling through the Crime Bill, because there's a data and research section in there, and I was trying to find out how much money we had, and the scary thing it says is that we've authorized such sums as are necessary which if—the reason it's scary is it could mean none or just a whole lot depending on how smart we are going to be. There's $1.8 billion in the Senate Violence Against Women Act for 3 years. Billion. B as in billion. And so NOW Legal Defense Fund isn't the research and data experts, but it sounds like we have a room full of people right now.

If I were you, I wouldn't leave town before you went and talked to Senator Biden's staff people, found out what this meant about these appropriations and authorizations, and then drop a note to Janet Reno, if you met her at the press conference today, to make sure that if some of that money goes through the Attorney General's office, it's targeted to go through the National, some of it go through the National Academy of Sciences, but if they reject it, it says any nonprofit private entity recommended by the academy.

So I mean, there's just, this is all real footloose and fancy free. There is not much adult supervision here, but the potential—that's how we pass all of our laws, you guys know that. The potential for everything we're talking about is in the $1.8 billion. We can either let it fritter away or we can go target it early. We have about 3 weeks, 3 to 6 weeks, before this is signed by the President, and you can be sure that the people who don't care as much as we do know

about this in here. There are some mysterious grants that Orrin Hatch put in that States can get up to a million dollars, and I think they just have to be within the Continental United States. There are very few guidelines.

So we should be working with the States to get some of that million dollars. I mean, you have to work on the issue of violence, but we ought to getting in there—and we didn't target elderly. I apologize. We targeted Native Americans. We did race, we did all sorts of groups. Let's go right now and say to Joe Biden, "We forgot." And then let's go talk to Jack Brooks and say, "We forgot." And we'll just put in little parens or a comma in there and put age, and nobody will know. I mean, they build whole missiles in conference committee and we never know it.

So I'm willing to try to do that, but I need all of you, and see, you're the pollinators. You got me together with these research people. We would have been in different fields, never meeting, and the pollinator blips around like the little bee, and we end up having responsibility for each other's future.

Ms. ARAVANIS. That sounded like a good action agenda, Pat, and we might hold you to that one, if you don't mind.

Dr. WOLF. Can I just raise a question? Didn't we hear this morning that the House only comes in at $800 million? And the real issue is to try to get the House up to the $1 billion. So that's another major effort.

Ms. ARAVANIS. Good point. Any other comments about data or research? Yes, Dwayne? If you could use the microphone again, Dwayne, thank you.

Mr. REAGAN. This talk about the authorizations and the appropriation of money is all nice, and you talk about going to my boss and then you know where the letters get answered. And the other thing is that if you don't go up there when the authorizations are being talked about and discussed, they do nothing. So it isn't just one shot, it's the authorization, and then when it gets to the appropriate committees for the, really, the money talks, the appropriation, you've got to talk there.

Ms. REUSS. There's miracle money here that Senator Byrd has found, as you recall, Government workers are losing their jobs at 25 percent cut, and we're going to save this money for the Crime Bill. So I call it magic dust. If it exists, we ought to be out there in the magic dust. I mean, how many of us believed in Santa Claus until we found out really for sure he didn't exist, for many years? So help me on this one. This is a funny incidence that, you're right, normally we have to be up there hour after hour tracking the money.

Ms. ARAVANIS. Toshio, I'm going to have to move on from the data and research issue, because we have several others that we need to address here. And the next question is I think one of OWL's favorite arenas, and that is this whole area of prevention. How can we encourage the empowerment of mid-life and older people who are involved in violent producing or violent characterized situations? What are the particular characteristics of midlife and older women that need to be considered in developing these prevention and intervention strategies? And finally, I guess, what good practices can we adopt from each other in this whole arena of pre-

vention, with the whole underlying theme of empowerment? Handy, you have some comments on that one.

Mr. BRANDENBURG. If I hadn't had to pick the item that I did when we did the introductions, I think this is the one that I would have commented on, and that is the recommendation in the OWL material about increases in home and community-based care. It just seems to me that for this to have an impact that's real for the midlife and elderly women that we're talking about, we don't have the resources there today, and there has to be additional resources. Now, where that comes from, again, we're talking serious public policy issues, and matters of priority that perhaps need to get argued out very seriously.

Ms. ARAVANIS. Another comment, Terry?

Dr. FULMER. I was hoping Lou would speak to the National Academy of Geriatrics piece that really speaks to this, too, and that is the socioeconomic status issue which is right there on the surface of all of this. In my work, people referred for protective services were more likely to be non-white, poor, uninsured. In Mark Lach's data, similar.

Lou, what are we talking, these are markers, so are those the people we go and really worry about? And yes, it will be costly.

Ms. GLASSE. Well, thank you, Terry. I can only speak to a part of it, but it certainly seems to me that it's a very close connection between the economic circumstances of the family unit and abuse. We know that under any circumstances, economic insecurity adds to tension. If there is also dysfunction of either the perpetrator or the victim, then the probabilities increase for abuse. As we all know, oftentimes the abused elder is the only one who has any income. They may be abused because of the interaction of dependency and the financial circumstances.

Here again, the data will be very helpful to us. But we know that under normal circumstances, having money gives you greater power. Therefore, the capacity to be independent is terribly important to preserve one's sense of self-determination.

When these problems develop, the capacity of the aging network and other community services are terribly important. The connection between income and health care may be critical. When a person does not have sufficient money, then they are less likely to get health care. The lack of health care may contribute to creating conditions that erupt in abuse.

Dr. FULMER. The only follow-up point I would have, and I think that says it well, is that in the midwifery world, there is a move right now to really fund doula's. Do people know what doula's are? Doula's are women who are trained to go to the homes of women who are economically, you know, down and out, to teach them mothering, parenting skills. And there is a big push on to fund that for the prevention of child abuse, neglect, and illness in the child. We might learn something from that model. You're obviously familiar with that. You might comment on whether you think that some sort of parallel thing could occur.

Ms. BROWN. I would agree with that direction. In many cases, we find that caregivers not only are burdened by the enormity of dealing with an aging person, with multiple chronic illnesses, but aren't aware of available resources that could be quickly brought to bear

to the whole picture, just literally don't know. There are a variety of resources that really could lighten the stress.

Ms. ARAVANIS. Go ahead.

Dr. WOLF. I want to reaffirm what Lou Glasse has said, about the complexity of the economic factor. We know that probably one of the most predictive factor or risk factor for the physical abuse of older persons by an adult child is the financial dependency of that adult child on the victim. Because that adult child is unable to hold a job or is mentally ill, the income of the victim supports the household.

Rather than discuss the victim and the perpetrator, it might be more helpful to view the situation from a family perspective. Beside the financial dependency of the perpetrator on the victim, there is often an emotional dependency of the victim on the perpetrator, or a "web of mutual dependency."

And so empowerment goes beyond just seeing that the person has the financial needs met. It is understanding the relationships and overcoming some of the pathological dependency that exists in these families.

Ms. ARAVANIS. Anything you would want to add, Joan, to that whole issue of the empowerment arena and ways we can focus on prevention?

Ms. KURIANSKY. Well, I think an important dimension to prevention is public education. We must do a better job of getting to where women are, whether it is at their health care provider's office, churches, synagogues or where they are getting certain kinds of benefits. Women must be given enough information to learn there is a name to what is going on, and that there are some resources out there to help them. An outreach strategy should anticipate barriers, whether it's outreach under a protective services or battered women's program.

Prevention begins with an understanding of the underlying causes of violence. I agree with Frances' comments about the imbalance of power, and the need for women to have a place in which she feels safe. This is as important as any social services that might later become available to her.

One of the reasons that women stay in abusive situations is because of their financial dependency. And even if a woman is working, she is more likely working at a job that doesn't give her enough income to be financially self-sufficient.

Ms. ARAVANIS. Anybody in the audience have anything they would like to add in the arena of prevention? What do we need to put in place that would help keep midlife and older women from getting into these circumstances and focusing on the empowerment issue?

BARBARA HOBBY, FAIRFAX COUNTY ADULT PROTECTIVE SERVICES

Ms. HOBBY. I'm Barbara Hobby, I'm with Fairfax County Adult Protective Services, so I'm on the front line. I'm the supervisor of one of the units there.

I guess this is more from my own personal experience as a social worker and my own view. I'm a little bit afraid about community

care, although I believe community care is important and people never want to leave their homes, and that's important.

But when you talk about empowerment, it's the women in our society that have always felt that they had to take care of children, they had to take care of parents, and I'm really, really frightened that they're the ones, they're not being empowered, they're being told that you now have to take care of your parent or your spouse, and you're responsible and the guilt that will go with that, that does go with that, and the overwhelming feelings of inability to deal with the situation makes it very, very difficult for women. And it's just a question that I wanted to bring up, something that I feel strongly about, because I don't want to happen to women what's happened to us when it comes to children.

Ms. ARAVANIS. Good point.

Yes, go ahead.

CAROLYN HERRING, ALEXANDRIA, VA

Ms. HERRING. I am Carolyn Herring, and I work in crisis intervention in Alexandria, Virginia. I am a—I don't like to say the word victim, but I have had spousal abuse. I have lived in the shelter with my children, and I want to address this issue. Women do not come forward because they know that things are tied up in red tape and legal gibberish. Violence is violence whether it's male, female, elder, young women, and bodies of women all over this world are being found and nothing done about it.

So I think when it all comes down to it, it's great to gain data, and it crosses all socioeconomic levels, perhaps more so in poor, because things happen when people are in poverty. Anger, there's a lot of anger, perhaps more so. But I don't care how rich you are, there's still anger, and things that have to be addressed, and most of all, when we become a nation that is insensitive, and we do nothing but talk and don't talk action against perpetrators of the violence, then it will continue, it will get worse, our children see it, and they become violent. And I think we have a country that is seeing this now. So because you are here talking about it, great. But I do think that perpetrators must pay the penalties. Thank you.

Ms. ARAVANIS. Good point.

I think it was also important that you brought up the whole issue of "red tape," and the difficulty of weaving through various systems. That is one of the reasons that we are here together, trying to find out what is the path for midlife and older women to get appropriate services without red tape from both the domestic violence and the aging network. So I'm glad you brought that up, and I think we're trying to go in that direction.

MILLIE STEINBERG, WASHINGTON, DC

Ms. STEINBERG. Well, I've had the courage, as this meeting was going on, to write something about my feelings. Believe me, nothing that I'm saying is critical of anything that anybody said here. I'm wholeheartedly in favor.

But I want to present another aspect to this, and I'm going to read what I wrote, if I may.

Ms. ARAVANIS. Could you say your name, please?

Ms. STEINBERG. My name is Millie Steinberg. I live in Washington, D.C.

Ms. ARAVANIS. Thank you.

Ms. STEINBERG. And I'm very proud to say that the very first bureau that addressed itself to victims of rape and victims of spouse abuse happened because I was a legislator in Suffolk County, New York, way back in 1973. So I'm very, very much steeped in it.

But this is another aspect. It's taken a little courage to stand here and say it. Thank you, Pam, you're the one who gave me the courage. Abuse, abuse. Why does it happen to me? Am I so weak that I cannot seek the courage to say "Stand back. I'm ready to give your penis a whack. Get off my back. Your male agenda does not make you the ruler over me." All of us must look at each other and say, just because I'm female doesn't mean I'm inferior to thee.

Let us go back to the moment when our great country took the courageous step of throwing off the monarchy to become a democracy. Equality, equality raised its glorious head. We are all going to be treated as equals. Alack and alas, the fathers were there, but the mothers were left at home to guard the fires, so that the fathers stated in their way, thinking that fathers included all people. The Constitution says, "We, the people of this country, in order to form a more perfect union, do hereby declare that all men are created equal." And there we have the beginning of our tyranny. All men are created equal? It should read "All people are created equal." When all of us, male as well as female, truly believe that all of us are equal, we will have the strength to hold our heads high and to spit in the eye of the male who is trying beyond belief to submit us to the indignity of the male who cannot accept the fact that all people are created equal.

You know, Alice Paul, and I can't remember Maggie's name, I'll just—just one little more.

Ms. ARAVANIS. Thank you.

Ms. STEINBERG. But the Equal Rights Amendment can be the beginning, and as we relate the reality of that which we call domestic violence, it can give us the strength, as individuals to face the ugly reality which in turn can be addressed by society as a whole to eradicate this ugly part of the relations between male and female. Once we have established, and more importantly, accepted as fundamental truth that all people are created equal, we can face the ugly facts of our life, such as inadequate health services, poor housing, male domestic abuse, shabby nursing homes, etc., etc. Our stance can gain strength, because we are the foundation of equality, can give us the muscle with which to fill in the gap that other unhealthy relations shield. The ERA cannot resolve the abuse, but it can give us a platform to give us the strength to face to abolish it.

Ms. ARAVANIS. Thank you for doing that. And thank you for feeling empowered to share your thoughts on that. It does take a lot to stand up and say what's on your mind sometimes, and we're glad you did.

Handy, you had a point as well.

Mr. BRANDENBURG. As I was listening to the remarks of the lady from Fairfax, it made me flash back to the time I spent with the Alzheimer's Commission in Maryland. And maybe one of the serv-

ces that ought to get some priority is respite care. Because it was dentified in our Alzheimer's Association discussions, and has come ıp in other arenas, and I think perhaps has, although we've talked ıbout needing to define and look at what are some of the things ɔehind a lot of these issues, I think that the stress on family units, ınd I'm speaking now primarily again in the domestic as opposed ɔ institutional setting, that the importance of respite care is per-ıaps, deserves some additional attention.

Ms. ARAVANIS. Great, thank you.

Terry, and then Elma.

Ms. FULMER. Sara, you talk about prevention, and just for the ecord, I'm wondering if there's a way that we can tap into Joe McGinnis' Office of Health Promotion and Disease Prevention, vhere people like Hurdis Griffith are, to say, you know, where are he funds from your office to help us take this on?

Ms. ARAVANIS. Okay, Elma, go ahead.

Ms. HOLDER. In the empowerment area, there has been, where t's tried, there's real success where nursing assistants have sup-ɔort groups working in facilities. And often the opportunity for ıursing assistants to be together and to be able to express their ɔncerns about their workplace and their needs for training, etc., ıas empowered them to then approach facility management to hange conditions for them.

That's one area that there was a good example of what can hap-en. I think that both nursing assistants and nurses and other ɔrkers in nursing homes are tremendously overworked, and as I ad mentioned before, often do double shifts. This is not uncommon t all. Recently, there was a situation in Florida where, and it's the rst time I've ever heard of this, actually, in all of my years of ɔrk on nursing home issues, that professional nurses organized, rst they, within the system, with the nursing home industry, ap-roached the leaders and decisionmakers in the industry to say We do not have enough nurses to provide the care that we want provide. We're understaffed and challenge the industry to do ɔmething about it."

They thought that the industry was going to take a stand and elp them go to the State to do what was necessary to get moneys, nd in the long run, the industry didn't support the nurses in that ffort. So then the nurses became more organized and took aggres-ve stands.

And I think it's, it is particularly interesting in nursing homes ıat often, the workers are women and that the decisionmakers are ɜually, the people who handle the money and the budgets, are ɜually corporations dominated by males. And we find most often ıat workers, and particularly professional nurses, will tend to, in-ead of standing publicly up against the system, will just quit ɔrking in nursing homes. They'll just resign and say, you know, tried it, and it didn't work." So I think related to the whole ɪpowerment issue, there's a lot, a strong need for us to support ırses and nursing assistants in standing up against the establish-ent, which doesn't let them give the care that they know they ed to give.

Ms. ARAVANIS. Good point.

Go ahead, Lou has a comment on that.

Ms. GLASSE. Yes, this reminded me that certainly in the reporting again, drawing back on my experience in New York, the report on nursing home abuse during that time was oftentimes traced back to lack of training, lack of supervision, lack of training and the inability of, the lack of knowledge of knowing how to treat a troublesome patient or how to handle someone who was physically frail.

I think this is, the timing of this is terribly important when we see, as Joan mentioned to us, a health reform, we're on the fringes of enacting a national health reform act, which we hope includes this long-term care, which would provide us, for the first time, some significant care within the home and within the community. And we, people who are involved in the Administration who see the future of what can occur in the expansion of home care if the President's proposal is enacted, expect that there will be a real surge in the availability of care in the home.

We have to be sure that that includes adequate training, so that there is quality care, we can assure that there is quality care, and that those home care workers, those supervisory workers then are really prepared to deal with the problems of frailty. And so therefore, this is an important preventive measure, it seems to me, that we can be involved in right now to make sure that we don't have this perpetuation of abused people within the home because of lack of training and lack of adequate conditions for their employment.

Ms. ARAVANIS. Go ahead, Lori.

Ms. STIEGEL. I want to comment and thank OWL for the inclusion of the recommendation regarding guardianship training, and accountability of guardians under preventive measures. Because I think that's a link that's not often made, between guardians who don't know what they're doing, and then the elders who they abuse as a result of that. The ABA has not taken a position on Federal guardianship legislation, and I personally don't agree with that, for a variety of reasons. But I think there's a lot that can be done at the national, State, and local levels to develop and promote training of guardians and then monitoring and ensuring their accountability.

Ms. ARAVANIS. Good point. Thank you.

Yes, Pat.

Ms. REUSS. I've been working on this issue 20 years, but 4 years intensively, night and day. And we've begged for ideas for prevention, and we've scoured the Nation for some agreement on prevention for the abusers, rapists, and assaulters, mostly. And there's no unanimity, so I can't report happy endings for you. In my own family, we have a designated driver, and I'm usually the designated drinker, but my sons are the designated drivers. And we've come to accept the responsibility because of MADD, and their national campaign, coupled with losing your license and going to jail, I mean, there were penalties there. We've yet to figure out how to have a similar campaign which causes people to interfere in what is normally very private activity, to go into a home where your own personal, cultural and religious philosophy tells you you don't belong—I don't want people in my home—to report things that if it was a stranger, if I saw a policeman beating you, I would report it. If I saw a policeman beating his wife, how many of us would

report that? I don't know even if I would, if I had the courage to do it.

So our prevention, we've got to have sort of a national campaign of discomfort that it's not, that indeed there's no excuse. That's our campaign. And then we've got to be a little pushy about it and combine doctors and law enforcement people. And so hopefully we can come back to all of you with a role in that for all of you. Certainly the people who see us, our friends, our family, our service providers, medical providers, social service people.

Ms. ARAVANIS. Yes, we have a comment from the audience.

CAROL RUPEL, LEGISLATIVE DIRECTOR, GENERAL FEDERATION OF WOMEN'S CLUBS

Ms. RUPEL. Yes, I'm Carol Rupel, and I'm Legislative Director for the General Federation of Women's Clubs.

I don't know much about elder abuse, but I do know a little bit about child abuse and the connection is, respite care is a good idea. This may not be a new idea, but in the legislation affecting child abuse, the home visiting program is getting a lot of airing. People are convinced that by training volunteers, training them well, you can prevent child abuse. And I would guess this would be true with elder abuse. I'm sympathetic in some ways to these caretakers. In following the health care reform and other elder issues, we hear that respite care is the most important thing.

After seeing elderly people care for their spouses and watching even younger people care for their parents, I would think that they need psychological relief. And if you could turn a corps of volunteers like the General Federation of Women's Clubs and many others into trained respite care workers, you might be able to thwart some of these problems.

Ms. ARAVANIS. Good point. And we appreciate——

Ms. REUSS. And you have over 200,000 members, right?

Ms. RUPEL. Yes.

Ms. ARAVANIS. We appreciate you coming forward with that opportunity and identifying another major entity, a major group of concerned people who could be part of this campaign that Pat is talking about.

Let me just move on quickly, as our time is moving, to major policy changes, policy reaffirmation, policy modification, new policy needed. Where do we need to go with laws and regulations at the state, Federal, and community level? Are there burning issues that you think need to be addressed in that arena? Rosalie.

Ms. WOLF. I was very pleased to see in the 1991 report of this committee the suggestion that a proportion or percentage of the social service block grant might be designated for elder abuse protection services. It seems to me reviewing what has happened in the last 10 years with the social service block grant, the fact that it has decreased in total amount as well as in the value of those dollars while reporting has increased that adult protective services have been placed in a very weak position, and in some States, even piped out.

Although I know the rationale behind the social service block grant, it may be time to reconsider the present arrangement and

advocate for a catagorical approach to funding, which would provide a minimum level of funding for APS.

Ms. ARAVANIS. Other comments? Other policy issues, regulation changes that you would like to get on the agenda, make sure OWL knows about, the Committee knows about? Elma.

Ms. HOLDER. I would be remiss if I didn't call on the Elder Women's League and the Senate Special Committee to help us get the enforcement regulations out for the 1987 Nursing Home Reform Law. It's been many years and the industry has had quite a grace period to get used to the law, and we really haven't had full enforcement. They're predicting that maybe they'll come out at the end of 1994, so it's been almost 6 years now, so we need to get those regs out, in particular because they have in the enforcement provisions the provisions on abuse and neglect.

Ms. ARAVANIS. Okay. Any other burning policy issues, policy regulation changes? Pat, go ahead.

Ms. REUSS. I have so many, but I haven't thought them through, and I'm sorry that I've been a little busy doing other things, so can I come back, maybe? I think that you're right, we have laws on the books that some of us are out suing because they aren't being enforced. If we all just held hands and said we're going to turn blue and half of those might be enforced, and we at least would be better off.

We have—1987 is kind of new. We have stuff that goes even farther back than that that deal with discrimination and whatever, and a lot of people aren't losing money they should be losing, because they're taking Government money and discriminating with it. So I think that we should demand that the laws that are in place be enforced, and have lots of wonderful lawyers who look at those, and we should make a list of those. So we're going to be nice for now, and then if you aren't enforcing them we'll come back in.

Ms. ARAVANIS. Tom, you had one.

Mr. CARLUCCIO. The domestic victims that have been suffering for many years are finally starting to realize that we all want to stop the bleeding. But what's happening now is that we're attempting to stop the bleeding, we have the laws but we don't have the people, the long-term care people in my State have 400 or 500, 600 cases. How can they deal with it effectively? How can they do an investigation and give it to me to prosecute? As domestic violence cases are starting to get priority, there are domestic violence units in my State, there are five prosecutors when there were none. There are social workers. It has not happened for elder abuse. And it's just beginning to happen with domestic.

But the training, as I said, the judges aren't trained, the prosecutors aren't trained, so therefore, when they get a case, what do they do with it? So the money, the block of money has to be put to training and it has to be put to hiring more people to deal with it. If we want to deal with it, then let's pay for it. Because referrals are coming in, and my office cannot keep up with them.

Ms. ARAVANIS. Good point.

Terry, yes.

Dr. FULMER. I think that that is so right, and I also think that we need to be very strategic about who our partners are as we lobby for money. And the point has already been made about

power. And I think that's why, for example, I'm very happy if the AMA wants to take this issue on. They're powerful. And the American Nurses Association could work for 10 years and not achieve what they can achieve in a month. It's just a fact. So we need to be smart about it and lobby carefully and get the groups behind it who can, who have power. The issue of why they have that much power is different. That's a whole other thing. But it's like what do you want to get done first?

Ms. ARAVANIS. Any other comments on that issue? Yes, Elma.

Ms. HOLDER. We have had a curious situation occur over the last 3 years where we've done a lot of cursory research, at least, to try to get at how much it costs to give poor care, and we call this the high cost of poor care. But you can literally trace that there are billions of dollars spent giving poor care and the worst part of that is the victims, the people who are neglected and abused and don't get care, so the human suffering is unbelievable.

But when we brought this to the attention here on the Hill, what we discovered is that people did not want to talk about moneys that are currently in the system. So we were saying, look, if it costs $10,000 to take care of a bedsore that never should have occurred in the first place, that's money that could be used to hire new staff, to do enforcement, to have better surveys. But we found that Congress didn't want to listen, and still doesn't tend to listen to moneys that are currently in the system. You can only find new moneys.

So we have a real reluctance to look at how we can be better accountable for the moneys that are actually there, and we need some help with that for people to really point out how much, it's literally billions of dollars, are spent unnecessarily in dehydration, pneumonia, bedsores, contractures, you name it, that residents in nursing homes, we don't provide the care under Medicaid, we turn the people over after they're abused and neglected into hospitals, and then we pay the billions of dollars out of Medicare, but because that's a Federal system, the money, it's just a horrible abuse of the elderly people because of that lack of recognition.

Dr. FULMER. Elma, where have you been all my life?

Ms. ARAVANIS. Speaking of where people have been all your life: What difference is this—that you have been called to this panel and that you have had the chance to interrelate with different disciplines around some different issues going to make to you? Would any of you want to make any comment about how this is going to affect your involvement in the OWL agenda? I wish you would do so at this time, as we're getting close to the end.

Ms. REUSS. I have a list of everybody's names, addresses, phone numbers and fax, they'll never get away from me today.

Ms. ARAVANIS. That's a very substantive issue.

Ms. REUSS. You're going to get on my legislative alert forever.

Ms. ARAVANIS. Good. That's a good, substantive follow-up. Go ahead, Toshio.

Dr. TATARA. Yes. I am very appreciative of many of the recommendations, and glad to see that a large number of them pertain to elder abuse, which is very refreshing. Specific recommendations that are included in my written response relate to our activities—and we can assure you that many of the activities, I don't

want to go into the recommendations now—will be implemented to the extent possible by our center, and we will report back to you. And we are very appreciative of including these specific things.

I want to say something else, though. Many things are happening in elder abuse in the past year or so. I would suggest that there has been a great deal of awareness that is happening about elder abuse in many spheres of the society. Those things have resulted in many organized activities that are sponsored by many different professional organizations. They happen in the medical area, they are sponsored by the American Medical Association. They happen in the legal and the law enforcement area, most prominently the conference that was sponsored by the Justice Department, and also other activities that were done by law enforcement related organizations addressing elder abuse.

I think what is happening is this. Someone mentioned earlier "medicalization of elder abuse." Another thing is happening, too. Law enforcement people have become more sensitized. And not only sensitized, but their sensitivity has been put into action, and they are putting money into organizing conferences and developing materials and so forth. We are at a confluence of large forces that are coming forward. And this is an opportunity, too, that we should take advantage of.

Given that, though, I am a little apprehensive about using the catchword "violence" to describe all forms of domestic violence, including elder abuse. I think that this is a time to look at each form of "violence," abusive behavior, more thoughtfully, to find out causes of these, and try to develop a definition that may be unique to each form of abuse, rather than trying to come up with a catchword to describe all of them.

Ms. ARAVANIS. Thank you, Toshio.

Anybody else have any comments about what you're going to do?

Dr. WOLF. We know that States are very limited in the amount of funds they have to put into adult protective services and other required services. Having OWL recognize elder abuse as an issue for support and advocacy will help communities in meeting the needs of their abused and neglected seniors. I hope that in the future, as we start to build coalitions or community groups, we will be able to call upon OWL groups as partners in some of these efforts.

Ms. ARAVANIS. Good point. Yes, Tom.

Mr. CARLUCCIO. As far as criminal, I go back, and I started out doing robberies and burglaries, I usually tell this spiel here. It was very simple to prosecute that type of crime, because you had the police, you train them to go in there and find out who the perpetrator was, and if somebody put a gun to someone's head, you took them in front of the courts and they're found guilty and you move on.

Totally different picture here. If everybody here doesn't do their job before I get it, I don't have a job to do. So I need the research people to do their job to find out why these things are happening and what is abuse, and find out where, what we need to prosecute and what laws we need to change. And the legislative people have to pass those laws. Then the long-term care ombudsmen and adult

protective services have to go out and gather the evidence so they can give it to our office to prosecute.

If one part of the system breaks down, it doesn't go. Where in a regular robbery case, a policeman goes out, gathers the evidence, interviews a few witnesses and we go on. But if somebody tells a caretaker, or if somebody goes into a house and doesn't gather that evidence or doesn't interview that person correctly, the battered wife or whoever, we don't have the evidence. And so there has to be an understanding, and these people right here have to give me the understanding before I can do my job and hopefully protect the victims out there.

Ms. ARAVANIS. A very important summation of our linkage to each other, I think, and how we do need each other in order to do a better job, with older women and midlife women who are in violent situations.

Joan, did you have any comments to make as an ending comment here today? We're almost right on time.

Dr. FULMER. Sara, Just one other liaison that's crucial, and again, Lou, I defer to you, the Women's Health Initiative at NIH is a place that if it ever gets off paper into reality that we should be absolutely camped out at their doorstep. And I'm hoping we will be.

Ms. ARAVANIS. Good point.

Joan, do you have any closing comments?

Ms. KURIANSKY. Well, our closing comments should be our opening comments for what happens next.

It was very useful, to have all of you from somewhat different disciplines come together today to look at this very multi-faceted issue. We must still answer the question of what an older woman should do to get the support she needs. What we would recommend? Do we suggest if she is over 65 that she go through the protective services system? Do we suggest that she file a private civil complaint? Do we suggest she go through the social service network that is set up by the aging network, or one that is offered through the battered women's movement?

Do we suggest to a concerned friend or child of a parent who is in a nursing home without other options that they fight for her rights in that nursing home, knowing that when the dark and the weekends come, we really don't have much ability to protect her from any retaliation that may take place?

We have many questions, still to be answered. Today the dialogue begins rather than ends. I thank you, invite all of you who can to join us at our open house this afternoon. Our offices are located at 666 11th Street, at G and 11th. We would be delighted to conclude what has been a full day, with a celebration. We began the day with comments from the President, through Attorney General Janet Reno, and now concluded with this afternoon's roundtable. Thank you for opening the door to this issue.

Ms. ARAVANIS. Good, thank you.

Lou, do you have any closing comments?

Ms. GLASSE. I think Joan said it well, and I want to thank everybody here for coming also. I'm very appreciative, and Sara, I commend you, and Senate staff as well. Also, please convey our great

appreciation to the Senators and to the Committee for their real support in making this happen.

Ms. ARAVANIS. I think we have sensitized ourselves, we have learned. I know I have made a list of good ideas, and I'm sure each of you have as well. In response to Joan's closing, and her posing of dilemmas, I think the strength of what we have done here today is that by knowing about each other, by knowing about the parameters of each program, we indeed, as persons in service to older people, can offer older people more choices about how they can affect their own lives and their own decisionmaking. That in itself is a major step forward.

Now that we know more about many of the available resources including professional women, the Department of Justice activities, the Andrus Gerontology Center, all of this will certainly help improve the lives of older people. That is why we are here.

I appreciate your cooperation with moving everything along, and I look forward to talking with you at the open house. Thank you very much.

[Whereupon, at 3:58 p.m., the workshop was concluded.]

APPENDIX

Understanding the Nature and Scope of Domestic Elder Abuse with the Use of State Aggregate Data: Summaries of the Key Findings of a National Survey of State APS and Aging Agencies

Toshio Tatara, PhD

ABSTRACT. This study summarizes the major findings of a survey of the state adult protective service (APS) agencies and state units on aging concerning domestic elder abuse reports, conducted by the National Aging Resource Center on Elder Abuse (NARCEA) in the fall of 1991. Data on reports of domestic elder maltreatment supplied by states were aggregated and analyzed, and descriptive summaries of key data items were prepared. In addition, using some of the statistics gathered by the survey and existing relevant information, an attempt was made to determine the national incidence of domestic elder abuse, the preliminary results of which are presented here.

INTRODUCTION

This paper summarizes the key findings of a mail survey of the state adult protective service (APS) agencies and state units on

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aging that was designed to collect statistical data on elder abuse in domestic settings for 1990 and 1991. In all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands (a total of 54 jurisdictions), the state APS agencies and/or state units on aging are designated by state statutes to receive reports of domestic elder abuse. Although some state agencies do not regularly collect data on these reports, most maintain some key statistics for domestic elder abuse reports. The survey, conducted by the National Aging Resource Center on Elder Abuse (NARCEA) in the fall of 1991, was designed to provide a better understanding of the characteristics of these reports.[1]

BACKGROUND

The abuse, neglect, and exploitation of elderly people occurring in homes (referred to as "elder abuse in domestic settings" or "domestic elder abuse") are serious problems in the United States. Studies by researchers and reports from professionals working with the elderly suggest that elder abuse in domestic settings is widespread and affects thousands of vulnerable elderly people across the country. However, because it is still largely hidden in the shroud of family secrecy, domestic elder abuse is hard to detect and is, therefore, grossly underreported. Pillemer and Finkelhor (1988), for example, estimate that only 1 out of about 14 domestic elder abuse cases (excluding self-neglect cases) comes to the attention of authorities. If this estimate is accurate, the domestic elder abuse reports made to state APS agencies and state units on aging represent the tip of the iceberg.

Researchers generally have utilized three distinct sources of data to study the nature and extent of domestic elder abuse. These three data sources are: (1) a sample of elderly people chosen from some clinical population (e.g., the elderly who were served by the social service agency); (2) a random sample of the elderly selected from the general population; and (3) elder abuse reports received by APS or aging agencies. Study purposes, sample sizes, and data collection methods varied considerably among studies of domestic elder abuse, and so did the findings. But most of the studies attempted to

generate estimates of the national prevalence or incidence of elder abuse in domestic settings.

The prevalence of domestic elder abuse, as estimated by researchers, ranged between 1 and 10 percent of the sample of elders studied or of the national elder population. Gioglio and Blakemore (1983), for example, found that only 1 percent of the elderly respondents of their random survey were victims of some form of abuse, but Lau and Kosberg (1979) reported that 9.6 percent of the elderly clients served by an agency in Cleveland, Ohio, had been abused by informal care providers. Additionally, Steinmetz (1981) estimated that 10 percent of the U.S. elderly population, or 2.5 million people, were victims of elder abuse. More recently, after conducting interviews with a random sample of more than 2,000 elderly persons in the Boston metropolitan area, Pillemer and Finkelhor (1988) reported that the prevalence of domestic elder abuse (excluding self-neglect and financial exploitation) was 32 per every 1,000 elders (or 3.2 percent). Using this rate, the researchers concluded that there were an estimated 701,000 to 1,093,560 abused elders in the country. Many other researchers surveyed or interviewed professionals working with the elderly (Douglas, Hickey, & Noel, 1980; O'Malley, Segars, Perez, Mitchell, & Knuepfel, 1979; Sengstock & Liang, 1982) and offered various types of information about the nature and scope of elder maltreatment.

To date, only a few studies have utilized data on elder abuse reports compiled by state APS agencies and state units on aging. At least two factors appear to have contributed to the scarcity of this type of elder abuse study in this country: (1) state information systems on elder abuse were not well developed and were unable to generate reliable and consistent data sought by researchers; and (2) there was a tendency on the part of researchers, particularly those from academia, to mistrust data gathered by other people, especially social service agencies. Nonetheless, some exploratory efforts to use domestic elder abuse data generated by state information systems have been made in recent years. For example, Tatara (1989) attempted to develop national estimates based on the number of domestic elder abuse reports for fiscal years 1983, 1984, and 1985. Largely because the number of states that used "comparable elder abuse definitions" was very small and the available state data

were incomplete, Tatara's first study of state-generated data on domestic elder abuse reports did not result in national estimates that may be useful to policymakers or researchers. However, the study did identify some of the major issues and problems inherent in the use of data collected and supplied by state information systems.

Subsequently, after analyzing the much improved domestic elder abuse data provided by states, Tatara (1990) estimated that, nationwide, a total of 140,000 reports of elder maltreatment in domestic settings were received during 1988. He noted that this 1988 figure represented a small but steady increase (19.7 percent) in the number of domestic elder abuse reports from 1986 (117,000) to 1988 (140,000). In addition, Tatara provided many other analyses of domestic elder abuse data supplied by states, and for the first time information was made available about such data items as the "types of domestic elder maltreatment reported," the "characteristics of elder abuse perpetrators," the "elder abuse substantiation rates," and the "elder abuse reporting rates in urban and rural states." The results that are presented in this paper are derived from the nation's second attempt to utilize state aggregate data on *reported* cases of elder abuse for the purpose of better understanding the nature and magnitude of elder maltreatment in domestic settings.

DATA COLLECTION METHODOLOGY

In the late fall of 1991, NARCEA designed and mailed a data collection instrument, "A Survey of State APS and Aging Agencies on Elder Abuse in Domestic Settings for FY 90 and FY 91," to the state APS agencies and state units on aging in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands (a total of 54 jurisdictions). The data collection instrument contained a total of 12 questions that were intended to obtain several different types of state domestic elder abuse data for 1990 and 1991. These different types of data are: (1) elder abuse incidence data (e.g., the total number of reports of domestic elder abuse, the total number of elderly persons involved in the reports of abuse and the type of reporters of elder abuse); (2) data on the types and frequencies of domestic elder abuse; (3) data on the characteristics of abusers (e.g., the sex and types of abusers); (4) data on the characteristics of

victims (e.g., the number, sex, and ages of victims); and (5) data on the characteristics of self-neglecting elders (e.g., the number, sex, and ages of self-neglecting elders).

Although the definitions of seven different categories of domestic elder maltreatment were provided in the data collection instrument for reference purposes, NARCEA allowed states to use their own definitions of domestic elder abuse. The seven categories of elder maltreatment are: (1) physical abuse, (2) sexual abuse, (3) emotional or psychological abuse, (4) neglect, (5) financial or material exploitation, (6) all other types (i.e., the state-defined abuse categories that do not belong to the above five categories), and (7) self-abuse/neglect. The definitions of these maltreatment types used by NARCEA are very similar to the existing federal definitions of elder abuse included in the Older Americans Act (Section 144). Finally, NARCEA requested that states use "60 years of age and older" as the definition of elderly, which is consistent with the federal definition of older people under the Older Americans Act.

RESPONSE RATE AND LIMITATIONS OF THE SURVEY RESULTS

A total of 74 different agencies from 52 jurisdictions responded to the survey, representing 49 states, the District of Columbia, Puerto Rico, and the Virgin Islands. Guam and Indiana did not participate in the survey. The completeness of data provided by states varied widely among the responding states[2] and from one data item to another. A number of state units on aging returned the data collection instruments without data, stating that they do not receive reports of domestic elder abuse and, therefore, do not have any data requested by the survey. The item that generated data from the most states was the "number of domestic elder abuse reports received for 1990," which came from 46 states. The number of states that reported statistics for other items was considerably smaller; for example, some items received data from less than 20 states. As a result, this study was unable to draw a complete national picture of the nature and extent of domestic elder abuse problems in the United States. Additionally, some data provided by a number of states were either incomplete (e.g., data that were collected from a period short-

er than 12 months) or were not consistent with NARCEA's instructions (e.g., data that included only the elderly who are 65 years of age or older). When any technically sound adjustments were possible with these data, appropriate measures were taken, and the data were included in the analyses.

SUMMARY OF KEY FINDINGS

National Estimates of Domestic Elder Abuse Reports

During 1990, an estimated 211,000 reports of domestic elder abuse were received nationally. But the number rose to 227,000 in 1991, a 7.6 percent increase in one year. These figures represent the national estimates of the counts of domestic elder abuse reports that were generated on the basis of the actual number of reports provided by fewer than 50 states. The numbers for the remaining jurisdictions were estimated. The author's previous data collection on domestic elder abuse resulted in the following national estimates of elder abuse reports: 117,000 reports for 1986; 128,000, 1987; and 140,000, 1988. Overall, from 1986 to 1991, there was an increase of 94.0 percent in the count of domestic elder abuse reports received nationwide. In particular, the rate of growth in the number of such reports from 1988 to 1991 was dramatic: during 1991, the nation's APS and aging agencies received 62.1 percent more reports of domestic elder abuse than they did during 1988.

Number of the Elderly Involved in Domestic Elder Abuse Reports

The count of elder abuse reports does not necessarily represent the number of elderly people who are allegedly maltreated. The count of reports is often "duplicated" in the sense that multiple reports of abuse or neglect made for one elder are included and some reports involve more than one victim. These types of duplication are intrinsic to many of the data gathered from social service information systems, and as yet there is no perfect way to correct the problem.

A review of the responses from the 39 states that provided NAR-

CEA with complete data for both 1990 and 1991 revealed that in 22 states, the count of reports was somewhat *larger* than the count of suspected victims, while both counts were the same in the remaining 17 states. Overall, in these 39 states, the count of suspected victims was 10 percent lower than the count of reports in 1990 and 9.3 percent lower in 1991. Thus, if the same relationship between the two counts holds true nationally, the estimated number of suspected victims included in the reports of domestic elder abuse probably was 190,000 for 1990 and 206,000 for 1991. These figures represent only the number of older people whose alleged maltreatment in domestic settings was reported to authorities nationwide and should not be confused with the national incidence of domestic elder abuse. Table 1 displays the national estimates of the counts of both domestic elder abuse reports and suspected elder victims for 1990 and 1991.

Reporters of Domestic Elder Abuse

Although states accept reports of elder abuse from anyone, most state adult protective service or elder abuse laws designate certain professionals as reporters of elder abuse. The exact categories of elder abuse reporters identified by state laws vary considerably from one state to another. Some states designate fewer categories of reporters than others, while the terminology used by states to describe the same type of reporters often differs among the states. Because of these reasons, it is extremely difficult to create a list of elder abuse reporters (regardless of whether they are mandated by law or not) that would be acceptable to all states. For the purpose of

TABLE 1

National Estimates of Domestic Elder Abuse Reports and the Elderly Included in the Reports for 1990 and 1991

	Count of Reports	Count of the Elderly
1990	211,000	190,000
1991	227,000	206,000

the survey, NARCEA developed a list containing eight specific categories of reporters and requested that states use the category "all other types" to report data on the reporters that did not belong to the NARCEA-supplied eight categories.

A total of 29 states for 1990 and 25 states for 1991 were able to provide data on the types of domestic elder abuser reporters. Table 2 presents a summary of the information given by these states. Although the number of states that provided data differed from one

TABLE 2

Categories of Reporters of Domestic Elder Abuse Reports for 1990 and 1991

	Percentage of Reports Made	
Reporter Category	1990 (N = 29)*	1991 (N = 25)*
Service provider	28.1%	26.7%
All other types	18.7%	21.0%
Physician/health care professional	17.0%	18.0%
Family member/relative	14.9%	15.0%
Friend/neighbor	8.8%	8.2%
Elder victim	5.6%	4.6%
Law enforcement	4.3%	4.3%
Unknown/missing data	2.2%	2.0%
Bank/business	0.2%	0.2%
Clergy	0.1%	0.1%
	99.9%**	100.1%

* The number of states that provided data.
** Due to rounding errors, the total is not exactly 100.0%.

year to another, the pattern of state responses was very similar. For both years, service providers (e.g., typically the providers of homemaker/chore services, home health, personal care, and other in-home services) were the most frequent reporters of domestic elder abuse. Health care professionals, including physicians, were the second most frequent reporters of elder abuse. Additionally, family members or relatives of the alleged victims were the third most frequent reporters, following closely behind physicians and other health care personnel.

Domestic elder abuse reports made by friends and neighbors of the alleged abuse victims accounted for less than 10.0 percent of all elder abuse reports, and law enforcement officials reported even less frequently than friends and neighbors for both 1990 and 1991. Further, the survey found that the clergy, bank officers, and people in business establishments *do* make reports of domestic elder abuse, but they still are among the least frequent reporters. Finally, the reporters included by states in the category "all other types" varied widely; some examples are: anonymous person, abuser, guardian ad litem, utility company, respite caregiver, and landlord. Some of these reporters could have been included in the categories of reporters listed in the survey instrument.

Elder Abuse Substantiation Rates

APS or aging agencies, and other agencies that receive reports of domestic elder abuse, investigate each report to determine whether the alleged maltreatment actually occurred. If the alleged maltreatment described in a report is confirmed based on evidence, the agency concludes that the report has been "substantiated," and appropriate measures are taken to protect the victim from further harm. Not all reports of domestic elder abuse are substantiated.

A total of 33 states for 1990 and 30 states for 1991 were able to generate statistics needed to calculate the substantiation rates of domestic elder abuse reports. Table 3 presents the overall substantiation (and non-substantiation) rates for both fiscal years. The overall substantiation rates of domestic elder abuse among the states that provided data were 54.5 percent for 1990 and 54.6 percent for 1991. In other words, these states substantiated the majority of the reports that they had investigated during both years. In 1990, about one-

TABLE 3

Domestic Elder Abuse Substantiation Rates for 1990 and 1991

	Percentage	
Type of Investigation Result	1990 (N=33)*	1991 (N=30)*
Substantiated	54.5%	54.6%
Unsubstantiated	32.0%	38.2%
Result Unknown**	13.5%	7.3%
Totals:	100.0%	100.1%

* The number of states that provided data.
** The reports were investigated but the state information systems do not have information about the result.

third of the investigated reports (32.0 percent) were unsubstantiated, somewhat less than the investigated unsubstantiated reports in 1991 (38.2 percent). The substantiated reports included *both* the cases in which elders were maltreated by other people and the cases of self-neglect. Table 4 provides the breakdown of the substantiated reports into the "abuse of others" and "self-neglect" categories.

As shown in the table, more than one-half of the substantiated reports each year were reports on self-neglecting elders. The reports on elders who were maltreated by other people accounted for about two-fifths of the substantiated reports in both years. However, the substantiated reports on self-neglecting elders represented a much smaller proportion of the elder abuse reports that were investigated: 31.5 percent for 1990 and 28.1 percent for 1991. Also, the substantiated reports on "abuse by others" were only 21.2 percent of the reports of domestic elder abuse that were investigated for 1990 and 24.4 percent for 1991. These percentages (not shown in Table 4) were calculated using the "raw" data collected from states. These analyses make it clear that APS and aging agencies serve a considerably larger number of self-neglect cases than cases involving victims of maltreatment perpetrated by other people. An analysis of

TABLE 4

Breakdown of Substantiated Reports into "Abuse by Others" and "Self-Neglect" Categories for 1990 and 1991

	Percentage	
Type of Investigation Result	1990 (N = 33)*	1991 (N = 30)*
Abuse by Others	38.9%	44.6%
Self-Neglect	57.8%	51.4%
Result Unknown**	3.3%	4.0%
Totals:	100.0%	100.0%

* The number of states that provided data.
** The reports were substantiated but the state information systems do not have information about the categories of the reports.

data from 30 states indicates, for example, that these states handled 15.2 percent more cases of self-neglect during 1991 than cases where elders were abused, neglected, or exploited by others.

Types and Frequencies of Elder Abuse

State statistics for the types and frequencies of domestic elder abuse requested by the survey did not include counts of self-neglect cases and addressed only the substantiated reports involving victims of maltreatment. Data on self-neglect cases were collected separately and will be analyzed later in this paper. A total of 29 states for 1990 and 30 states for 1991 provided complete data on the NARCEA-supplied list of domestic elder abuse categories. Table 5 presents a summary of these data. The frequencies of domestic elder abuse incidents across different maltreatment categories reported by the states were almost identical in each year. Neglect by others, the most frequent type, accounted for nearly one-half of the substantiated reports. Physical abuse, the second most frequent type of maltreatment, included about one-fifth of the substantiated reports. Further,

TABLE 5

Types and Frequencies of Domestic Elder Abuse for 1990 and 1991

	Percentage	
Type of Maltreatment*	FY90 (N=29)**	FY91 (N=30)**
Neglect	46.6%	45.2%
Physical Abuse	20.3%	19.1%
Financial/material exploitation	17.4%	17.1%
Psychological/emotional abuse	11.6%	13.8%
All other types	3.3%	4.0%
Sexual Abuse	0.6%	0.6%
Unknown/missing data	0.2%	0.2%
Totals:	100.0%	100.0%

* Statistics collected from states include *only* the substantiated reports involving abuse victims and does *not* include self-neglect reports.

** The number of states that provided data.

financial or material exploitation ranked third and occurred somewhat less frequently than physical abuse in the states that provided data. Most states included psychological/emotional abuse in their definitions of domestic elder abuse, but this type of maltreatment represented slightly more than one-tenth of all substantiated reports. Finally, sexual abuse represented a very small percentage of the substantiated reports among the states that provided data. However, some states also include sexual abuse in the physical abuse category.

Characteristics of Abusers

Many states had difficulty providing data on the perpetrators of domestic elder abuse; for example, data on the sex of abusers were available only from 17 states for 1990 and from 18 states for 1991.

TABLE 6

Sex of Abusers for 1990 and 1991

	Percentage	
Sex of Abuser	1990 (N = 17)*	1991 (N = 18)*
Male	52.3%	51.8%
Female	41.8%	42.5%
Unknown/missing data	5.8%	5.8%
Totals:	99.9%**	100.1%**

* The number of states that provided data.
** Due to rounding errors, the totals are not exactly 100.0%.

As Table 6 shows, the majority of abusers of the elderly in domestic settings are males. These statistics for the sex of abusers were generated from the counts of substantiated reports of elder abuse. Because only about one-third of the states provided data, it is not certain whether the rates on the sex of abusers presented in the above table will hold true nationally.

Data on the relationships of abusers to victims were provided by 21 states for both 1990 and 1991. These data, also derived from the counts of substantiated reports of elder maltreatment, are presented in Table 7. Adult children of the elder victims were the most frequent abusers and were involved in about one-third of the substantiated reports for both years. Spouses (both sexes) were the second most frequent abusers, but their involvement in elder abuse was only about one-half that of adult children. The category, "other relatives," ranked third and accounted for over one-tenth of the substantiated reports. Service providers, neighbors/friends, and the victim's grandchildren and siblings were identified as abusers in less than 10 percent of the substantiated reports of domestic elder abuse. Finally, the category, "all other categories," which accounted for about one-sixth of all substantiated reports, included

TABLE 7

Relationship of Abusers to Victims in Substantiated Reports for 1990 and 1991

	Percentage	
Type of Relationship	1990 (N=21)*	1991 (N=21)*
Adult children	31.9%	32.5%
All other categories**	16.7%	18.2%
Spouse	15.4%	14.4%
Other relatives	13.0%	12.5%
Friend/neighbor	7.3%	7.5%
Service provider	6.6%	6.3%
Grandchildren	4.0%	4.2%
Sibling	2.6%	2.5%
Unknown/missing data	2.5%	2.0%
	100.0%	100.1%***

* The number of states that provided data.
** States use a wide variety of definitions of abusers to collect information about the relationship of abusers to victims and included the types of abusers not provided in the survey instrument in this category. It is not possible to break out these percentages.
*** Due to rounding errors, the total is not exactly 100.0%.

such people as unrelated caregivers, former spouses, housemates and former housemates, and paramours.

Characteristics of Elder Abuse Victims

Information about the sex of elder abuse victims, shown in Table 8, was available from 28 states for 1990 and 29 states for

TABLE 8

Sex of Elder Abuse Victims for 1990 and 1991

	Percentage	
Sex of Victim	1990 (N = 28)*	1991 (N = 29)*
Male	31.3%	32.0%
Female	68.6%	67.8%
Unknown/missing data	0.2%	0.2%
Totals	100.1%**	100.0%

* The number of states that provided data.
** Due to rounding errors, the totals are not exactly 100.0%.

1991. About two-thirds of elder abuse victims were females. Based on data for 1991, the ratio of male victims to female victims is 1 to 2.2, indicating that women are twice as likely as men to be victims of domestic elder abuse.

Statistics showing the ages of elder abuse victims were available from 22 states for 1990 and 25 states for 1991 and are summarized in Table 9. As illustrated in Table 9, the age characteristics of domestic elder abuse victims are very similar for 1990 and 1991. Elderly people who are 85 years of age and older appear to be most vulnerable and represent the age group involving the largest number of elder abuse victims. This age group accounted for slightly more than one-fifth of the abuse victims for both years. Further, about two-fifths of all domestic elder abuse victims are 80 years of age and older. Thus, the data reveal that elders in the younger age groups (i.e., the "60-64" and "65-69" groups) are less likely than their older counterparts to become victims of domestic elder abuse. In fact, the number of elder abuse victims who are in the "60-64" age group was only one-third of the number of victims who were in the "85 and up" age group. The median ages of elder abuse victims calculated from the above data were 78.5 years for 1990 and 78.8 years for 1991.

TABLE 9

Ages of Elder Abuse Victims for 1990 and 1991

	Percentage	
Age Category	1990 (N=22)*	1991 (N=25)*
60-64	7.8%	7.6%
65-69	11.2%	10.5%
70-74	15.0%	15.5%
75-79	17.4%	17.1%
80-84	19.2%	19.4%
85 and up	22.2%	23.1%
Missing data	7.2%	6.8%
Totals:	100.0%	100.0%

* The number of states that provided data.

Characteristics of Self-Neglecting Elders

The most comprehensive study to date of self-neglect was conducted by the National Association of Adult Protective Services Administrators (NAAPSA) and was released in 1991 (Duke). The study, which involved an indepth analysis of 1,684 APS cases from 30 states and the District of Columbia, generated useful information about the characteristics of self-neglecting APS clients. However, because it included both adults and elders served by APS agencies in the study population and because its data collection methodology differed from the methodology in this study, the findings of the NAAPSA study cannot be compared directly with those of this current effort. Twenty-six states provided NARCEA with the numbers of substantiated self-neglecting elders served for both 1990 (46,111 elders) and 1991 (47,458 elders) (Tatara, 1993). However,

because they came from fewer than one-half of the states surveyed, these figures cannot be used to generate the national incidence of self-neglect.

Under the current study, the information about the sex of self-neglecting elders is available from 21 states for 1990 and 23 states for 1991 and is presented in Table 10. As shown in the table below, for both fiscal years, nearly two-thirds of self-neglecting elders were females. These findings closely resemble the findings on the sex of elder abuse victims presented earlier. The data suggest that women are almost twice as likely as men to become victims of self-neglect.

For 1990 and 1991, 18 states and 19 states, respectively, provided data regarding the ages of self-neglecting elders, which is summarized in Table 11. The data from both years indicate that people who are older are more likely to be self-neglecting than those who are younger. For example, the elders who are older than 80 years of age accounted for nearly two-fifths of all substantiated self-neglecting elders for 1990 and 1991. On the other hand, the elderly who are younger than 70 years of age represented only about one-fifth of the self-neglecting elders. The median ages of self-neglecting elders were calculated to be: 77.3 years for 1990 and 77.8

TABLE 10

Sex of Self-Neglecting Elders for 1990 and 1991

Sex of Self-Neglecting Elders	Percentage	
	1990 (N=21)*	1991 (N=23)*
Male	34.4%	35.1%
Female	62.5%	62.1%
Unknown/missing data	3.2%	2.8%
Totals:	100.1%**	100.0%

* The number of states that provided data.
** Due to rounding errors, the total is not exactly 100.0%.

TABLE 11

Ages of Self-Neglecting Elders for FY 90 and FY 91

	Percentage	
Age Category	FY90 (N = 18)*	FY91 (N = 19)*
60-64	9.9%	9.4%
65-69	13.0%	11.8%
70-74	14.8%	15.3%
75-79	18.3%	16.7%
80-84	18.5%	18.8%
85 and up	18.0%	20.3%
Missing data	7.6%	7.6%
Totals:	100.1%**	99.9%**

* The number of states that provided data.
** Due to rounding errors, these totals are not exactly 100.0%.

years for 1991. Overall, self-neglecting elders were slightly younger than victims abused by others. For example, the median ages of elder abuse victims were 78.5 years for 1990 and 78.8 years for 1991.

A MODEL FOR DEVELOPING THE NATIONAL INCIDENCE OF DOMESTIC ELDER ABUSE

Although seldom done, the types of statistics collected by this study allow an exploratory attempt in estimating the national incidence of elder abuse in domestic settings. Using the data already presented earlier in this article, two sets of national incidence data for 1991 have been calculated: (1) the total estimated number of domestic elder abuse victims, *excluding* self-neglecting elders; and (2) the total estimated number of self-neglecting elders.

Total Estimated Number of Domestic Elder Abuse Victims in the Nation

The national estimate of elder abuse victims in domestic settings, *excluding* self-neglecting elders, for 1991 is 735,000. This figure represents the estimated total count of the elderly who were abused, neglected, or exploited by other people in this country during 1991. Only a small portion of these elder abuse victims were actually brought to the attention of authorities. Several steps were involved in the calculation of this national estimate, as follows:

Step 1. The total estimated number of domestic elder abuse reports received nationwide during 1991 was 227,000. The substantiation rate of reports involving elders who were abused by others was 25.5 percent of the elder abuse reports that were investigated in 30 states during 1991. If it can be assumed that the same rate holds true nationally, the total number of substantiated reports in the country would be 57,885 (227,000 × 0.255).

Step 2. The current study examined the relationship between the number of elder abuse reports and the count of elders included in the reports in 39 states and found that the latter was less than the former by 9.3 percent during 1991. If this finding is true nationally, the total number of elderly victims involved in the substantiated reports would be 52,502 (57,885 − [57,885 × 0.093]).

Step 3. If Pillemer and Finkelhor's 1988 finding that only 1 out of 14 elder abuse victims (excluding self-neglecting elders) come to the attention of authorities is true nationally, the total number of elder abuse victims in the country during 1991 would be approximately 735,000 (52,502 × 14).

Total Estimated Number of Self-Neglecting Elders in the Country

The national estimate of self-neglecting elders for 1991 is 842,000. Again, only a small fraction of these elders were reported

to authorities. The following steps were taken to generate this estimate:

Step 1. The total estimated number of domestic elder abuse reports received nationally during 1991 was 227,000. The substantiation rate of reports involving self-neglecting elders for the same year was 29.2 percent of the elder abuse reports that were investigated in 30 states. If the same rate holds true nationally, the total number of the substantiated self-neglect reports for 1991 would be 66,284 (227,000 × 0.292).

Step 2. The current study, based on data in 39 states, found that the count of elders was fewer, by 9.3 percent, than the number of reports received during 1991. If this relationship between the two sets of data is true nationally, the total number of self-neglecting elders involved in substantiated reports for 1991 would be 60,120 (66,284 − [66,284 × 0.093]).

Step 3. The earlier-mentioned reporting rate estimated by Pillemer and Finkelhor does not pertain to self-neglecting elders. To date, no studies have explored the reporting rates of self-neglect cases, and, therefore, it is not known how these cases are likely to be reported to authorities. However, if it can be assumed that the reporting rate for self-neglecting elders is about the same as the rate for other types of domestic elder abuse victims, the total number of self-neglecting elders for 1991 would be 841,680 or 842,000 (60,120 × 14).

In summary, the results of these explorations suggest that, nationwide, approximately 735,000 elderly people became victims of domestic elder maltreatment during 1991. In addition, about 842,000 elders were victims of self-neglect in the same year. But only small percentages of these people were reported to the agencies providing protective services for the elderly.

CONCLUSIONS

The current study relied on the data that were provided by state adult protective services and aging agencies, and there are a number

of limitations. For example, most of the data presented in the study were supplied by fewer than 30 states, and, therefore, cannot be assumed to be nationally representative. Also, for some data (e.g., the categories of elder abuse reporters, the relationship of abusers to victims), states' definitions varied widely, but the survey instrument was not appropriately equipped to capture information about the diverse practices of states. Further, there are indications that the data collected from states where local agencies administer elder abuse programs are incomplete because of the inability of some local agencies to gather data.

On the whole, however, the study shows that state information systems on elder abuse have improved markedly in recent years. The number of states that were able to provide key statistics for domestic state data have become more comparable today than they were several years ago. States are likely to achieve even greater comparability in their data collection practices as more states decide to incorporate NARCEA's suggested guidelines (Tatara, 1990) on the compilation of domestic elder abuse data into their information systems. In addition, now that the federal elder abuse program is firmly in place under Title VII of the Older Americans Act, it is likely that the federal government will take measures to help implement this program. Since strengthening state and local programs addressing elder abuse will be among federal priorities, it is anticipated that data collection practices of these programs will continue to improve.

In the meantime, the current study found that there has been a substantial increase in the number of reports of elder maltreatment in domestic settings in recent years. Although it cannot be determined whether this increase was solely due to a rise in the incidence of domestic elder abuse, it is clear that, nationwide, more people today are reporting suspected incidents of elder abuse to authorities than ever before. As public awareness of elder abuse is further enhanced, frequencies of elder abuse reporting are also likely to grow. This study found that there was an increase of 94.0 percent in the number of domestic elder abuse reports received nationwide from 1986 (117,000 reports) to 1991 (227,000). If these trends continue, it is not unreasonable to predict that the count of these reports will soon reach 300,000 nationally.

Although there are some shortcomings, the statistical summaries of domestic elder abuse presented in this paper should prove useful to policymakers, agency managers, researchers, and others concerned with elder abuse. The agency-generated data similar to those analyzed by this study are regularly utilized by professionals in many other human service fields (e.g., child protective services, child foster care) for policy development, resource allocation decisions, and program evaluation. In the field of elder abuse, it is not unrealistic to expect that agency-generated data will regularly contribute to policy and practice decisions in the not-so-distant future.

NOTES

1. The National Aging Resource Center on Elder Abuse (NARCEA) was supported by funding from the Administration on Aging (AoA) from October 1988 to September 1992. Since the termination of the federal grant, NARCEA has become a project of the American Public Welfare Association (APWA). More detailed information about the results of the survey was included in NARCEA's report, "Summaries of the Statistical Data on Elder Abuse in Domestic Settings for FY 90 and FY 91," released in February 1993.

2. Throughout the remaining paper, the term, "state," is used to address any of the 50 states, the District of Columbia, or any of the U.S. territories that participated in the survey.

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ELDER ABUSE: QUESTIONS AND ANSWERS

An Information Guide for Professionals and Concerned Citizens

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Contents

The purpose of this *Information Guide* is to help both professionals working with older people and concerned citizens enhance their awareness of the problems of abuse, neglect, and exploitation of the elderly in America. The *Guide* provides only basic information about elder abuse problems, and the programs and services that are available to serve victims, their families, and at-risk elders. Readers wishing to obtain more information are encouraged to contact aging or adult protective service agencies in their communities.

The development of the original publication was supported, in part, by a grant (No. 90-AM-0332) awarded to the American Public Welfare Association (APWA) by the Administration on Aging (AoA) in September 1988 to establish the National Aging Resource Center on Elder Abuse (NARCEA). Federal support for NARCEA ended in September 1992. Subsequently, the **National Center on Elder Abuse (NCEA)** was created in September 1993 by another grant (No. 90-AM-0660) awarded to APWA.

This fourth edition is a *revised* version of the original publication released in September 1990 and includes new information. The views that are presented herein are those of the author and do not reflect the opinions or policies of the founding agency or the organizations participating in the operation of NCEA.

Margaret M. Rittman, M.A. (APWA) edited this publication and also obtained and selected the photographs with Maria R. Pippidis, M.A. (University of Delaware).

The **National Center on Elder Abuse (NCEA),** established by a cooperative agreement grant (No. 90-AM-0660) awarded to the American Public Welfare Association (APWA) by the Administration on Aging (AoA) in September 1993, is operated by a consortium of APWA, the National Association of State Units on Aging (NASUA), the University of Delaware (UD), and the National Committee for the Prevention of Elder Abuse (NCPEA). The purpose of NCEA is to perform clearinghouse functions by compiling and disseminating information about best practices to combat elder abuse; develop, publish, and disseminate information about materials, facts, and issues of importance to professionals and concerned citizens; provide training and technical assistance to a broad range of professionals; and conduct and support research and demonstration projects to help enhance an understanding of elder abuse and improve the delivery of services to victims and their families. NCEA publishes the quarterly newsletter, *NCEA EXCHANGE*, operates the Clearinghouse on the Abuse and Neglect of the Elderly (CANE), and develops and disseminates reports of national significance. Additionally, the staff of NCEA regularly participates in professional meetings, conferences, and public information events designed to address elder abuse issues.

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ELDER ABUSE: QUESTIONS AND ANSWERS

"Elder abuse is a shocking revelation to most Americans, and the average citizen may find it hard to believe that the problem exists. Studies suggest, however, that elder abuse is a widespread phenomenon, affecting hundreds of thousands of vulnerable people across all classes of society ... Because it is still largely hidden, elder abuse is difficult for the professional community to address effectively. Only with the support of the general public can we ensure that cases are brought to light and appropriate action is taken." (The Vexing Problem of Elder Abuse" in ***Public Welfare***, Spring 1988: 5.)

1. WHAT IS THE INCIDENCE OF ELDER ABUSE NATIONALLY?

The true incidence of elder abuse, like the true incidence of child abuse, is not known. Incidence research in the field of elder abuse is still an emerging discipline, mainly because the adult protective service information systems of most states, upon which incidence studies are typically

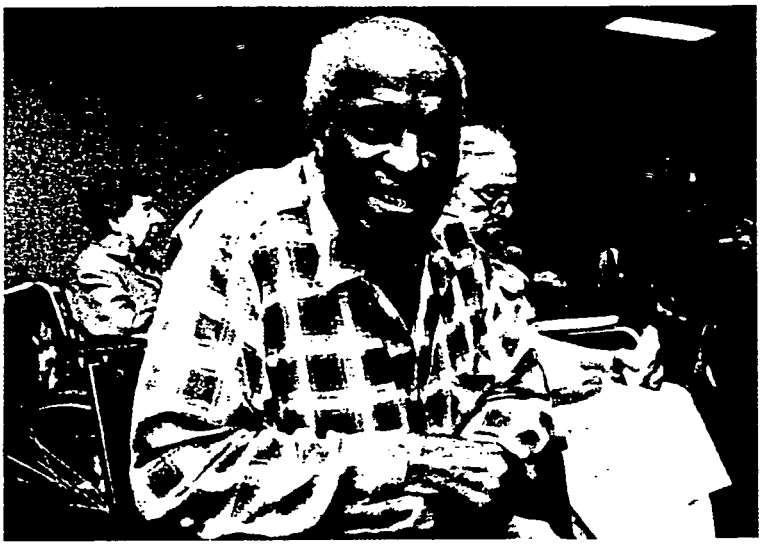


Photo: Martha Tabor / Working Images Photographs

based, are incomplete. However, some national estimates for the incidence of elder abuse are available; for example, according to the report, ***Elder Abuse: A Decade of Shame and Inaction,*** released in May 1990 by the Subcommittee on Health and Long-Term Care of the Select Committee on Aging of the U.S. House of Representatives, "about 5 percent of the nation's elderly may be victims of abuse from moderate to severe." The report further suggests that "about 1 out of every 20 older Americans, or more than 1.5 million persons, may be victims of such abuse each year." Similarly, the National Aging Resource Center on Elder Abuse (NARCEA) estimates that nearly 1.57 million older people became victims of domestic elder abuse during 1991.

Elder abuse is far less likely to be reported than child abuse, which has gained greater public awareness. A survey of states by the Subcommittee on Health and Long-Term Care found that "while 1 out of 3 child abuse cases is reported, only 1 out of every 8 cases of elder abuse is reported." Further, NARCEA's study of state adult protective service (APS) and aging agencies revealed that in 1991 only about 227,000 reports of abuse, neglect, and exploitation of the elderly in domestic settings were made, nationwide. Finally, statistical data on institutional elder abuse are so scarce that it is not possible to make any national estimates of its incidence. The Office of State Long-Term Care Ombudsman in each state does maintain some data on "complaints" made by nursing home residents, but these data are not appropriate indicators of institutional elder abuse because they are incomplete and also include reports of complaints that do not constitute the abuse, neglect, or exploitation of elders.

2. IS ELDER ABUSE INCREASING? WHAT WILL THE FUTURE HOLD WITH RESPECT TO THIS PROBLEM?

Although it cannot be established whether the incidence of elder abuse itself is increasing, available data suggest that, nationwide, reports of elder abuse have

been increasing steadily in the past few years. For example, NARCEA's data show that there were 117,000 reports in 1986, 128,000 reports in 1987, and 140,000 reports in 1988. Further, NARCEA's recent study reveals that the number of reports reached 227,000 in 1991, signifying a 62.1 percent increase from 1988. With enhanced public awareness of the problem along with improved reporting systems in states, it is anticipated that reports of elder abuse (particularly domestic elder abuse) will continue to increase. For now, however, experts agree that elder abuse remains one of the most under-recognized, and therefore the most underreported, social problems in this country.

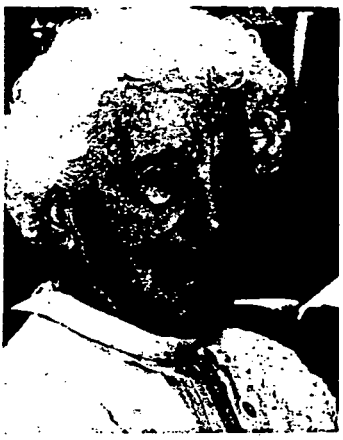


Photo: University Of Delaware/Robert Cohen

Elder abuse will be a growing problem in the next century. Currently, there are about 42 million older people (those who are 60 years of age or older) in this country, compared with 67 million children (those who are 18 years of age and younger). But, the elder population is rapidly growing each year, while the child population is showing only a very small rate of increase. The U.S. Census Bureau projects that, if the current trends continue, by 2020 the elder population will reach 72 million but the child population will drop to 66 million. Since it is likely that most of the elderly will live in their own homes, as they do now, the potential for increase in the reports and incidents of domestic elder abuse is enormous. Incidentally, the National Committee for Prevention of Child Abuse estimates that about 2.7 million reports of child abuse were received, nationwide, in 1991.

3. WHAT ARE THE MAJOR TYPES OF ELDER ABUSE?

Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in

the 1987 amendments to the Older Americans Act. These definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes. Currently, elder abuse is defined by state laws, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect, or exploitation of the elderly. In addition, researchers have used many different definitions to study the problem. Broadly defined, however, there are three basic categories of elder abuse: (1) domestic elder abuse; (2) institutional elder abuse; and (3) self-neglect or self-abuse. In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity.

Domestic elder abuse generally refers to any of several forms of mistreatment of an older person by someone who has a special relationship with the elder (e.g., a spouse, a sibling, a child, a friend, or a caregiver) in the older person's own home or in the home of a caregiver. Although the exact legal terminologies and definitions may vary from one state to another, most states recognize the following five types of domestic elder abuse and collect statistical data on their incidence:

- *Physical abuse* - non-accidental use of physical force that results in bodily injury, pain, or impairment.

- *Sexual abuse* - non-consensual sexual contact of any kind with an older person.

- *Emotional or psychological abuse* - willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other verbal or nonverbal abusive conduct.

- *Neglect* - willful or non-willful failure by the caregiver to fulfill his/her care-taking obligation or duty.

- *Financial or material exploitation* - unauthorized use of funds, property, or any resources of an older person.

Institutional abuse, on the other hand, generally refers to any of the above-mentioned forms of abuse that occur in residential facilities for older persons (e.g., nursing homes, foster homes, group homes, board and care facilities). Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection (e.g., paid caretakers, staff, professionals).

Self-neglect or self-abuse refers to the neglectful or abusive conduct of an older person directed at himself/herself that threatens the person's health or safety. Self-neglect or self-abuse usually occurs as a result of the older person's physical or mental impairment (or in a situation where the older person is socially isolated).

Depending on the statute of a given state, elder abuse may or may not be a crime. Most physical, sexual, and financial/material abuses are considered crimes in all states. In addition, depending on the type of the perpetrator's conduct and its consequences for the victims, certain emotional abuse and neglect cases are subject to criminal prosecution. However, self-neglect is not a crime in all jurisdictions, and, in fact, elder abuse laws of some states do not address self-neglect.

4. WHAT IS THE INCIDENCE OF EACH SPECIFIC TYPE OF ELDER ABUSE?

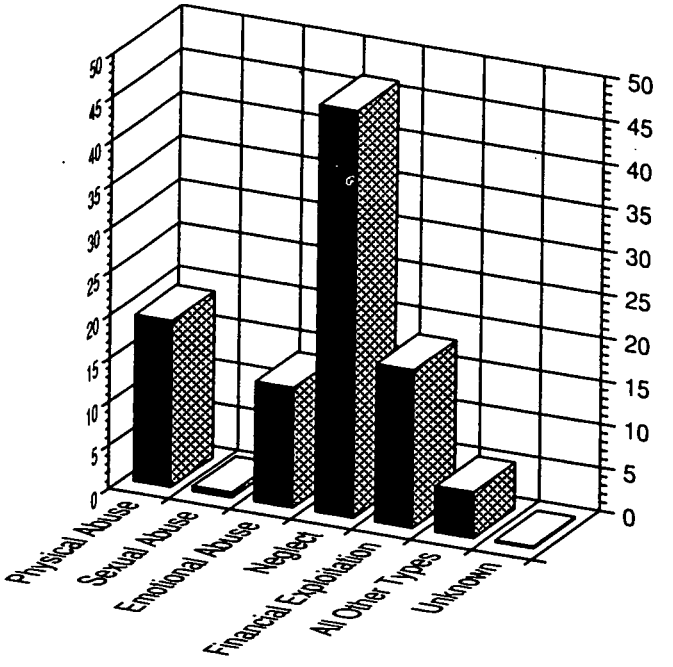
The majority of the confirmed cases or about one-third of all reports of elder abuse usually turn out to be self-neglect or self-abuse cases. For example, 51.4 percent of the confirmed cases in 30 states during 1991 were self-neglect or self-abuse cases. Overall, however, these cases accounted for 28.1 percent of all reports of elder maltreatment received in the 30 states during the same year. Most states offer appropriate protective services to the elderly who are "neglectful" of their own care, but the state gives careful consideration to an individual's right to refuse such services. Sometimes, guardianship is established for an older person or a decision is made to place an older person in an institution,

but these measures usually are used as the last resort for very impaired persons.

Based on statistics for confirmed domestic elder abuse cases reported by 30 states (which include only those cases that involve the elderly who were abused/ neglected by others and exclude self-neglect or self-abuse cases), NARCEA estimates the incidence of specific types of elder maltreatment for 1991, as follows:

Physical abuse	19.1%
Sexual abuse	0.6%
Emotional abuse	13.8%
Neglect	45.2%
Financial exploitation	17.1%
All other types	4.0%
Unknown	0.2%

While data from a number of other states were available, the definitions of elder abuse in these other states were not comparable with those of the above 30 states. Therefore, their data could not be included in the analysis. Further, it must be noted that the incidence of specific types



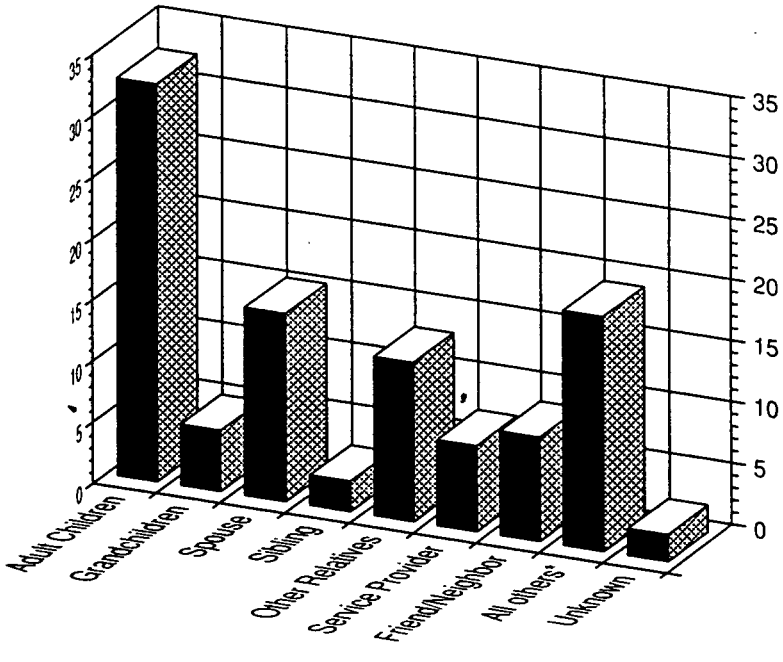
of elder abuse varies from one year to another. For example, NARCEA's earlier study found that physical abuse accounted for 26.3 percent of all confirmed cases in 1988, and the frequencies of other types of maltreatment in the same year also differed somewhat from those in 1991.

5. WHO ARE THE ABUSERS OF THE ELDERLY?

Although available data are from 21 states only, these 1991 statistics begin to provide a clear picture about the identity of those who are the perpetrators of elder abuse in the domestic setting, as follows:

Adult children	32.5%
Grandchildren	4.2%
Spouse	14.4%
Sibling	2.5%
Other relatives	12.5%
Service provider	6.3%
Friend/neighbor	7.5%
All others*	18.2%
Unknown	2.0%

*Self-neglect/abuse is not included.



About two-thirds of elder abuse perpetrators are family members of the victims. Child abuse data also show that nearly 70 percent of the perpetrators are members of the victims' families. Given these facts, it is reasonable to assume that both elder abuse and child abuse can best be understood within the context of "family violence" or "intra-familial conflict." Finally, the category, "all others," included such people as unrelated caregivers, former spouses, housemates and former housemates, and paramours.

6. WHAT ARE SOME CHARACTERISTICS OF ELDER ABUSE VICTIMS?

Approximately two-thirds of elder abuse victims in domestic settings are females. For example, data from 29 states show that 67.8 percent of the elderly who were abused, neglected, or exploited in 1991 were females. In addition, older elders tend to become victims of maltreatment: according to data from 25 states, elderly people who are 80 years of age or older made up more than two-fifths of domestic elder abuse victims in 1991. The median age of these victims was 78.8 years.

7. WHAT ARE SOME CHARACTERISTICS OF SELF-NEGLECTING ELDERS?

The majority of domestic elder abuse reports that are substantiated after investigations by APS and aging agencies each year are self-neglect or self-abuse cases. Available data reveal that about two-thirds of these cases involve females. For example, in 1991, 62.1 percent of the self-neglecting elders in 23 states were females. Additionally, data from 19 states show that in 1991, the median age of self-neglecting elders was 77.8 years, an age similar to the median age of victims of domestic elder abuse presented earlier.

8. WHAT ARE SOME CAUSES OF DOMESTIC ELDER ABUSE?

Elder abuse, like any other type of domestic violence, is extremely complex and many different factors contribute to its occurrence. It is generally

assumed that a combination of psychological, social, and economic factors that affect interpersonal and intra-familial relationships (along with the mental and physical conditions of the elderly themselves and the perpetrators) is responsible for any single incident of domestic elder abuse. Recent research studies have generated a number of theories and hypotheses about the reasons that certain types of elder maltreatment occur. At the same time, professionals working with victims, their families, and perpetrators have formed explanations of the causes of domestic elder abuse principally on the basis of clinical observations. The existing causal theories of domestic elder abuse can be divided into four major categories. These categories, however, are not independent of one another but are closely related. Also, a combination of different theories can best explain the cause of any particular incident of elder abuse.

- **Stress of the caregiver** — Caring for older people is a very difficult and stress-provoking task. This is particularly true when older people are mentally or physically impaired, when the caregiver is ill-equipped to perform care-taking tasks because of his/her personal problems or lack of knowledge of the job, or when support from other family members is lacking. This theory holds that abuse results from the stress and frustration of a caregiver in combination with other factors that are essentially "internal" to the caregiver (e.g., inadequate coping skills, emotional problems, loss of employment) along with those problems that are "external" to the caregiver (e.g., mental or physical impairment of the elder, financial burden, lack of family and community support). This theory is widely supported in the professional community as one that can explain the cause of a large number of abuse and neglect cases.

- **Impairment of dependent elders** — According to a recent study by the General Accounting Office (GAO), about 80 percent of the estimated 6 million dependent elders in this

country are cared for at home. Among them are many severely disabled older people who suffer from mental or physical disabilities, or both. Generally, researchers have found that elders in poor health are more likely to be abused than those in good health. There have been similar findings in child abuse research, as well. This theory also postulates that abuse often occurs in a situation where the stress level of the caregiver is heightened as a result of the elder person's increased dependency on the caregiver due to the worsening of the older person's impairment.

Cycle of violence — This theory holds that some families are more prone to violence than others, as violence is a learned behavior and is transmitted from one generation to another. Child abuse researchers found that many perpetrators of child maltreatment were, in fact, abused when they were children — frequently by their parents or caretakers. Researchers postulate that an abusive behavior (such as the use of violence to resolve conflict) becomes a normative behavioral pattern in some families, with members of these families practicing such behavior throughout their lives. Clinicians working in both the child abuse and elder abuse fields are very familiar with this theory because they have observed cases that involve family members from more than one generation.

- **Personal problems of abusers** — Researchers found that abusers of the elderly (typically adult children) tend to have more personal problems than do non-abusers. Professionals have observed that adult children who abuse their parents frequently suffer from such problems as mental and emotional disorders, alcoholism, drug addiction, and financial difficulty. Because of these problems, adult children are often dependent on the elders, whom they end up abusing, for their support (e.g., money, housing). This theory postulates that abuse of the elderly by these dependent children is, in fact, an inappropriate

response to the sense of their *own* inadequacies. This theory is noteworthy because about 30 percent of the perpetrators of domestic elder abuse are adult children of those who are being abused.

As mentioned earlier, no single theory can provide the complete explanation for the causes of domestic elder abuse. Also, each case of abuse is unique and involves several causal factors. Nonetheless, these major theories of the causes of domestic elder abuse provide a basis for understanding the reasons that certain incidents of elder abuse occur. It is also clear that more research in the area of elder abuse etiology is needed.

Photo: University Of Delaware/Robert Cohen

9. WHAT ARE SOME OF THE FEDERAL PROGRAMS THAT ADDRESS THE PROBLEM OF ELDER ABUSE?

Today, the only federal program that specifically addresses elder abuse is the elder abuse prevention program under Chapter 3, Title VII of the Older Americans Act. This federal program (which was originally authorized for $5 million in 1987 under Part G, Title III of the Older Americans Act) finally received a Congressional appropriation of $2.928 million in 1990 for fiscal year 1991 and currently supports some of the public education activities related mainly to domestic elder abuse at the state and local levels. Congress raised the amount of authorization for the program to $15 million when the Older Americans Act was reauthorized in 1992 but appropriated only $4.339 million for fiscal year 1993. In addition, the Older Americans Act provides states with funding to operate their Long-Term Care Ombudsman programs, which receive, investigate, and resolve

"complaints" made by or on behalf of residents of long-term care facilities. Some of these "complaints" are concerned with the mistreatment of older people. In 1992, Congress authorized $40 million for the long-term care ombudsman programs under Chapter 2, Title VII of the Older Americans Act but appropriated only $3.861 million for fiscal year 1993. Further, many state and local governments use funds from the Social Services Block Grant (SSBG) to support their adult protective service programs that usually include elder abuse programs. Additionally, aging agencies provide the elderly, including those who are victims of elder abuse and who are at-risk of being abused, with a variety of social services using funds from Title III of the Older Americans Act. Further, other federal programs, including Medicare and Medicaid, are frequently utilized by adult protective service and aging agencies, as well as medical facilities, for the treatment of elder abuse victims. Despite the availability of federal funding from these programs, federal resources still are very limited in the field of elder abuse.

It is important to mention that the Administration on Aging (AoA) in the federal government plays a key role in efforts to bring elder abuse issues to the fore on the national social policy agenda. As the federal administering agency of the Older Americans Act, AoA has funded numerous research, demonstration, evaluation, and training projects related to elder abuse. Because of these projects, a considerable amount of knowledge and information about the problem is available today, and there has been a great deal of improvement in state and local programs serving elder abuse victims

Photo: University Of Delaware/Robert Cohen

and their families. AoA's commitment to combatting the problem of elder abuse was shown by the agency's provision of funds to support the operation of the National Aging Resource Center on Elder Abuse (NARCEA) from 1988 to 1992. Further, in 1991, AoA launched a National Eldercare Campaign to mobilize resources for "older persons at risk of losing their independence." Those older people who are abused, neglected, or exploited were included in the target population of this national campaign, and AoA supported the activities of the National Eldercare Institute on Elder Abuse and State Long-Term Care Ombudsman Services, from 1991 to 1993. Additionally, AoA currently provides funding assistance to operate the new National Center on Elder Abuse (NCEA), which was created by the 1992 Amendments to the Older Americans Act.

Finally, the work of an Elder Abuse Task Force at the U.S. Department of Health and Human Services (HHS) must be noted. This task force, established by the Secretary of HHS in 1990, released a departmental action plan for the identification and prevention of elder abuse and neglect in the spring of 1992, following an extensive study of the problems by its members representing several agencies within HHS. Although there was a change in the federal administration in January 1993, efforts to implement this action plan (which started in the fall of 1992) have been incorporated into the current administration's initiatives to reduce family violence.

10. DO MANY STATES HAVE A REPORTING SYSTEM FOR ELDER ABUSE, LIKE THEY DO FOR CHILD ABUSE?

All 50 states, the District of Columbia, Guam, and the Virgin Islands have established some form of legislation addressing domestic or institutional elder abuse, along with reporting systems to identify elder abuse cases. However, these state statutes vary widely from one jurisdiction to another regarding the scope of provisions and the types of abuse covered. For example, many statutes cover both

adult abuse and elder abuse, while others address only elder abuse. A number of states address both domestic and institutional abuse with one law, while others have established separate legislation.

At the present time, a total of 42 states, the District of Columbia, Guam, and the Virgin Islands (45 jurisdictions) operate "mandatory reporting systems," whereby reporting of suspected elder abuse to authorities is mandatory for certain professionals. On the other hand, in eight states such reporting is voluntary, so citizens of these states can choose not to report suspected elder abuse. State statutes designate certain state or local agencies as the authorized agencies to receive reports or referrals of elder maltreatment. Throughout the country, the state or local APS agency is most frequently designated as the authorized report-receiving agency for domestic elder abuse. But other agencies such as the police department, the district attorney's office, the state unit on aging, and the area agency on aging also receive reports of elder abuse in many states. To ensure that all incidents of elder maltreatment are reported to appropriate authorities for investigation and protective services, many states operate state-wide, toll-free telephone systems, while others publicize the telephone numbers of the report- receiving agencies throughout the community.

Statutes of the states that operate mandatory reporting systems define certain professionals as mandated reporters who must report all suspected cases of elder maltreatment. Although the exact types of mandated reporters vary among states, such professionals as employees of the law enforcement agency, staff of the APS or aging agency, medical doctors and health care personnel, and staff of residential facilities are designated as mandated reporters of elder abuse in most states that maintain mandatory reporting systems. In addition, in some states the public also is required to report elder abuse cases.

Maintaining an effective reporting system is crucial because through the reporting system agencies that address elder abuse can identify and

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investigate suspected cases. A reporting system also enables the public and professionals to bring elder abuse incidents to the fore and allows states the opportunity to provide appropriate protective services or treatment to victims and their families in a timely manner. For these reasons, states devote a considerable amount of effort to improve their reporting systems.

11. WHAT ARE THE PROVISIONS OF STATE ELDER ABUSE LAWS PERTAINING TO THE CONFIDENTIALITY OF REPORTERS, PROTECTION FROM CIVIL OR CRIMINAL LIABILITY, AND THE PENALTY FOR NOT REPORTING?

Most state statutes require that the identities of persons who file reports of suspected elder maltreatment be kept confidential and disclosed only to the APS agency, law enforcement agency, or legal counsel, or by court order. Most states define any violation of this confidentiality as a misdemeanor punishable by a fine or imprisonment, or both. Additionally, "reporters"—those who report possible cases of elder abuse—are protected from civil or criminal liability. Most state laws specify that reporters will bear no civil or criminal liability for reporting suspected elder abuse, unless it can be proven that these reporters knew that the report was false.

Seventeen states have made the failure by a mandated reporter to report suspected elder maltreatment a misdemeanor punishable by a fine or imprisonment, or both. Mandated reporters must report all instances of elder abuse, neglect, or exploitation (as defined by state law) that they know to exist or reasonably should know to exist.

12. WHICH STATE AND LOCAL AGENCIES ARE HELPING VICTIMS AND THEIR FAMILIES INVOLVED IN ELDER ABUSE?

In most states, the APS agency, typically located within the human service

agency, is the principal public agency responsible for both investigating reported cases of elder abuse and for providing victims and their families with treatment and protective services. In most jurisdictions, the county departments of social services maintain an APS unit that serves the needs of local communities. However, many other public and private agencies and organizations are actively involved in efforts to protect vulnerable older persons from abuse, neglect, and exploitation. Some of these agencies include: the state unit on aging; the law enforcement agency (e.g., the police department, the district attorney's office, the court system, the sheriff's department); the medical examiner/coroner's office; hospitals and medical clinics; the state long-term care ombudsman's office; the health agency; the area agency on aging; the mental health agency; and the facility licensing/certification agency. Depending on the state law governing elder abuse, the exact roles and functions of these agencies vary widely from one jurisdiction to another. Finally, because funds under the new federal elder abuse prevention program are distributed to area agencies on aging (AAAs) across the country, the extent of these agencies' involvement with elder abuse services is likely to increase in the future.

Although most APS agencies also handle adult abuse cases (where clients are between 19 and 59 years of age), nearly 70 percent of their caseloads involve elder abuse. The APS community is relatively small compared with the groups working for other human service programs, but it is composed of a few thousand professionals, nationwide. However, it is anticipated that the size of the APS community will grow rapidly as the number of reports and referrals of elder maltreatment increases because of the growing awareness of the problem among professionals and the public.

Of the non-APS and non-aging agencies working in the elder abuse field, the role of law enforcement agencies and hospitals is extremely critical. Across the country, a growing number of law enforcement agencies recently have become concerned with elder abuse

problems. In the future, it is likely that more cases of elder maltreatment will be investigated and prosecuted. Additionally, a number of hospitals also have established an adult protective service unit within the hospital through the assistance of physicians and medical social workers. Given the possible medical service needs of most elder abuse victims, the involvement of medical professionals in the elder abuse field is very important.

Finally, it is noteworthy that the American Medical Association (AMA) has issued a publication, ***Diagnostic and Treatment Guidelines on Elder Abuse and Neglect,*** urging medical professionals to be more alert to signs of elder maltreatment. With these guidelines (which AMA distributed widely as part of its campaign against family violence), the awareness of physicians and other health care professionals about the growing problem of elder

Photo: Martha Tabor / Working Images Photographs

abuse is likely to increase greatly.

13. WHAT TYPES OF SERVICES ARE AVAILABLE FOR ELDER ABUSE VICTIMS AND THEIR FAMILIES?

Because elder abuse is a multi-dimensional problem, a variety of resources and many types of expertise are needed to provide victims with treatment and protective services that will ensure the health and safety of these vulnerable elders and their families. Today, many social service, medical, mental health, legal, and law enforcement resources are mobilized to address the challenges of elder maltreatment in communities across the country. The exact types of programs and services available vary considerably from one state to another and from one community to another.

Generally speaking, four types of services are being provided with varying degrees of emphasis in many communities: elder abuse treatment, protective services, prevention services, and support services. Since the scope and method of delivery of these services differ from one jurisdiction to another, only a general summary of each type of service is provided here:

Elder abuse treatment — The medical profession plays a key role in the clinical diagnosis and treatment of victims of elder abuse and neglect. Although statistics are not available, most major hospitals and medical centers across the country operate some type of program designed to identify, diagnose, and treat problems related to the abuse (both physical and sexual) and neglect (both emotional and non-emotional) of the elderly. Typically, physicians specializing in trauma/emergency medicine, assisted by a host of professionals (e.g., psychiatrists, geriatricians, psychologists, medical social workers, enterostomal therapists, nutritionists, geriatric nurses), provide leadership in many of these programs. Given that nearly 20 percent of elder abuse victims are known to have been physically or

sexually abused, the role of the medical profession is critical in the elder abuse field. In addition, medical care is frequently required for victims of certain types of elder neglect as well (e.g., patients with severe bed sores or with emotional problems). In addition to medical treatment, physical examinations, psychological evaluations, functional assessments, and a variety of tests for elder abuse victims or at-risk elders often are conducted in the medical setting.

Protective services — Protective services for the elderly are practiced primarily in the public agency setting. This situation can be explained by the fact that most state elder abuse statutes designate the public adult protective service (APS) agency, or other public agencies (e.g., a state unit on aging), as the lead agency in providing protective services, particularly in domestic elder abuse cases. However, for institutional abuse, the state long-term care ombudsman's office, the state unit on aging, or the state health department serve as the lead agency in some states. In all communities, the APS agency works in collaboration with many other public and private agencies (e.g., the police, prosecutor's office, the court system, client advocacy groups, hospitals, and social service providers) to maximize their effectiveness in serving the needs of vulnerable elderly people.

Although the specific content or scope of protective services varies among states, the APS agency in the state and local governments generally conducts the following activities: (1) the operation of a system to receive reports and referrals of suspected elder abuse, as defined by state law (i.e., the central registry system); (2) the investigation of cases of elder maltreatment by gathering evidence from the victim, family members, appropriate professionals, neighbors and friends, and others determined to be appropriate; (3) the substantiation or unsubstantiation of elder abuse reports based on evidence, agency policy, and state law; (4) the provision of emergency services to victims or their family members, as needed; (5) the administration

of assessments, tests, or evaluations, as needed; (6) the preparation of legal procedures, as needed; (7) the referral of cases to treatment and rehabilitation programs, substitute care programs, long-term care programs and law enforcement agencies, as appropriate; (8) the removal of the victim or the perpetrator from the home, when necessary; (9) the provision of support, protective, and advocacy services; (10) the training of agency staff, related professionals, and volunteers; (11) the administration of public awareness programs; and; (12) the collection of statistics for clients and services.

Prevention services — The most commonly used approach to elder abuse prevention is the provision of professional and public education programs at the community level. APS agencies, often in collaboration with other agencies, conduct programs aimed at increasing professional and public awareness of elder abuse problems. These programs also are designed to help both professionals and the public become familiar with

Photo: Martha Tabor / Working Images Photographs

"abuse/neglect indicators and warning signs." In addition, many states provide informal and professional caregivers and interested citizens with appropriate training related to the care of the elderly. These programs are known to help prevent the potential abuse and neglect of the elderly or to lead to the early identification of abuse and neglect cases, one of the most critical factors in elder abuse prevention and treatment programs.

Support services — Although the types and extent of services vary among states, a variety of support services are available to elder abuse victims or their families in many states. Such services generally include: the guardianship program, the guardian ad litem, legal advocacy, financial planning for the elderly, self-help groups, respite care, foster care and group homes, transportation, and socialization services, to cite only a few. These services are provided by public and private agencies serving the elderly.

14. HOW CAN I HELP?

Everyone can help in efforts to protect vulnerable older people from all types of abuse, neglect, and exploitation. Depending on who you are, your role may be different from that of others who are concerned about elder abuse.

First, if you are a concerned citizen, you can take the following steps:

- Contact the local public human service agency or the area agency on aging and obtain information about key provisions of your state's law addressing elder abuse, reporting guidelines, and types of services available to victims and their families. Most agencies have a brochure containing this type of information for a concerned citizen, like yourself.

- Study the reporting guidelines, which may list "indicators or warning signs" for different types of elder abuse, neglect, and exploitation, that are

tailored to your state's elder abuse law.

- Share the information with your relatives, friends, and neighbors.

- Ask the local public human service agency, the area agency on aging, or any other community-based agencies serving the elderly about their volunteer programs related to elder abuse and participate in any of these programs as a volunteer, if you can.

- Report to the authorized public agency, which receives elder abuse reports in your community, cases for which you have knowledge, or reasonably suspect, that abuse, neglect, or exploitation has occurred and that the elder's health (mental and physical) or safety is endangered. Consult your state's reporting guidelines for details.

Second, if you are a practicing professional in any human service field, you also can take the steps outlined for concerned citizens. In addition,

Photo: University Of Delaware / Robert Cohen

you can do the following to help yourself become more effective in the field of elder abuse:

- Familiarize yourself with your professional role and responsibility regarding elder maltreatment based on your state law on elder abuse.

- Regardless of whether or not you are among the mandated reporters, carefully study the reporting guidelines, procedures, and steps.

- Find out how other agencies (public and private) are supposed to be

involved in efforts to protect the elderly from maltreatment and their roles and responsibilities as they relate to elder abuse.

- Participate, when possible, in meetings, seminars, and conferences on elder abuse to improve your practice skills and develop networks of concerned professionals in your discipline and across different disciplines.

- Report to the authorized report-receiving agency any suspected cases of elder maltreatment as required (or encouraged) by your state law.

Third, if you happen to be a member of the academic community, either as a researcher or as an instructor, you could make a significant contribution to the field of elder abuse. As a researcher, you can undertake basic or applied research studies in any number of areas, including etiology of elder abuse, victimology, evaluation of reporting systems, assessment of service effectiveness, abuse in minority groups, validation of risk factors, and staffing and workloads, to cite only a few examples. Existing knowledge in any of these areas is still very limited, but the practitioner community will benefit greatly from research findings that can be applied to professional practice related to elder abuse. Finally, NARCEA's publication, ***Elder Abuse and Neglect: A National Research Agenda,*** provides a comprehensive list of research topics that, experts have agreed, need to be studied.

As an instructor concerned with the issue of elder abuse, your contributions to the elder abuse field would be great if your would be able to include, or increase the amount of, material related to aging and elder abuse. Some of the organizations that may provide you with information about the elder abuse literature and research studies are: the Clearinghouse on Abuse and Neglect of the Elderly (CANE) of NCEA (University of Delaware, Newark, Delaware 19716); the Association for Gerontology in Higher Education (1001 Connecticut Avenue, N.W.,

Suite 410, Washington, D.C. 20036); the American Association of Retired Persons (601 E Street, N.W., Washington, D.C. 20049); the American Medical Association (515 North State Street, Chicago, Illinois 60610); The National Committee for the Prevention of Elder Abuse (119 Belmont Street, Worcester, Massachusetts 01605); the Gerontological Society of America (1275 K Street, N.W., Suite 350, Washington, D.C. 20005-4006); and the National Long Term Care Ombudsman Resource Center (1224 M Street, N.W., #301, Washington, D.C. 20005). Additionally, the adult protective service agency or the state unit on aging will provide you with information about your state's laws and programs on the abuse, neglect, and exploitation of the elderly.

NATIONAL CENTER ON ELDER ABUSE (NCEA)

Consortium Organizations

American Public Welfare Association (APWA)
810 First Street, N.E.
Suite 500
Washington, D.C. 20002-4267

National Association of State Units on Aging (NASUA)
1225 I Street, N.W.
Suite 725
Washington, D.C. 20005

University of Delaware
College of Human Resources
Department of Textiles, Design, and Consumer Economics
Newark, Delaware 19716

National Committee for the Prevention of Elder Abuse (NCPEA)
c/o Institute on Aging
The Medical Center of Central Massachusetts
119 Belmont Street
Worcester, Massachusetts
01605

RESPONSE TO THE OLDER WOMEN'S LEAGUE CALL TO ACTION RECOMMENDATIONS TO END VIOLENCE AGAINST MIDLIFE AND OLDER WOMEN

Holly Ramsey-Klawsnik, Ph.D.*

I would like to thank the Older Women's League for their concern and attention to the problem of violence against midlife and older women, and to congratulate them on their "Call to Action" regarding this serious problem.

In addition, I would like to make the following comments in regard to the Older Women's League recommendations to end violence against midlife and older women.

I concur that the types of abuse reported through the National Center on Elder Abuse should be disaggregated by gender. While both elder men and women are vulnerable to abuse by family members and caregivers, two-thirds of the reported victims of domestic abuse against older persons reported in 1990 and 1991 were women (Tatara, 1993). In addition, the abuse of women tends to be more serious in nature and consequences (Pillemer & Finkelhor, 1988). Women differently abled due to physical and/or mental impairments are particularly vulnerable to violence and abuse. It is strongly recommended that all states and jurisdictions be required to provide data concerning violence against older adults to the National Center on Elder Abuse (NCEA).

Specific forms of violence against older persons should be accurately reported to NCEA by type (physical abuse, sexual abuse, psychological abuse, financial exploitation, neglect). Only 0.6% of the substantiated reports of abuse reported to NCEA in 1990 and 1991 involved sexual abuse of older persons (Tatara, 1993). However, this finding is misleading in that many states inaccurately tabulate sexual assault of older persons perpetrated by family members and caregivers as cases of physical abuse. The figure of 0.6% is further artificially diminished due to the fact that many states which mandate professionals to report suspicions of abuse of older individuals exclude sexual abuse as a reportable condition, requiring only the report of physical abuse, psychological abuse, financial abuse and neglect (Ramsey-Klawsnik, 1991). It is necessary to specifically require professionals to also report suspicions of sexual assault of older individuals so that victims can be identified and the necessary medical, social service and legal assistance can be offered. The omission of sexual abuse from the list of violent acts against older people which requires professional reporting, investigation, and service delivery does a major disservice to women. The overwhelming majority of older persons sexually assaulted by family members and caregivers are women (Ramsey-Klawsnik, 1991). Sexual abuse must be specifically included in the definition of elder abuse cited in all legislation, and cases of this type of serious assault must be tabulated as such.

I strongly support OWL's call for training for members of all disciplines who may be called upon to respond to a midlife or older woman who has been a victim of violence or exploitation. These include law enforcement officers; medical, nursing and emergency medical personnel; mental health and social work professionals, rape crisis counselors, Adult Protective Services workers and members of the judiciary. These key personnel likely to be called upon to offer assistance require specific information, sensitivity and intervention skills to effectively assist older women traumatized by violence or abuse. Providing this training in an interdisciplinary forum gets key personnel from differing systems together to discuss issues, build alliances and formulate networks to facilitate cooperation and coordination of services to victims. It is strongly recommended that members of these disciplines develop protocols for collaboration to better serve midlife and older women in their community who have been victimized.

Resources need to be made available to provide victims immediate safety and protection. Such resources are in short supply in most communities, and include, emergency medical services sensitive to the needs of older victims of domestic violence, including battering and sexual assault; emergency shelters equipped to serve older women; adult respite care homes; and for those with serious medical conditions, nursing home beds which can be accessed on an emergency basis. Resources also need to be made available to assist victims with more longer-term needs, such as victim counseling, assistance through the maze of legal intervention, alternative permanent housing and means of financial support if home and other financial resources were lost in the flight to safety, and, for impaired women dependent upon others for care, alternative, non-violent caregivers.

I support OWL's call for research, and would add that substance abuse by perpetrators of violent crimes against midlife and older women requires further attention.

Finally, I would like to underscore OWL's emphasis on education for women themselves. Empowerment and prevention are important approaches to reducing violence towards women. Midlife and older women must be aware of their rights, including their right to safety from physical, sexual and psychological intimidation by spouses, adult children, other family members, paid and unpaid caregivers. Women subject to victimization must be able to turn to society and find key professionals trained to assist with available, appropriate and responsive intervention and resources.

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Recognizing and Responding to Elder Maltreatment

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Mrs. N.[1] is an 81-year-old widow who lives alone and experiences a constellation of physical problems. She does not drive, and has difficulty managing the two flights of stairs to her apartment. Her 53-year-old son visits twice weekly, does her grocery shopping, picks up her medication at the pharmacy and assists with writing out her bills. He is divorced, alcoholic, and quick-tempered. He chronically insults Mrs. N., yells at her, and belittles her. Occasionally, he slaps and pushes her. He once pushed her on the stairs, after he became irritated that she was making her way up too slowly. She lost her balance, stumbled, but fortunately did not fall down the stairs. Mrs. N. is grateful that her son visits regularly and provides some assistance with tasks that are difficult for her to manage. Her response to his abusiveness is to be overly compliant, and to "stay out of his way" when he is intoxicated. She fears that if she complains to him or about him, his abusiveness will escalate, or worse yet, he will no longer visit.

Like many elders, Mrs. N. is in a bind: she needs and depends upon someone who treats her poorly and sometimes dangerously. She is a victim of elder maltreatment.

Elder maltreatment involves aggressive and neglectful acts which result in psychological and often physical damage to older Americans. It occurs in domestic as well as institutional settings. This article will describe elder maltreatment, focusing on abuse in domestic settings. It is designed to assist service providers in recognizing elder maltreatment, and to provide guidelines for responding to suspected cases.

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Characteristics of Elder Maltreatment

Prevalence

The true extent of elder maltreatment in our society is not known. A variety of studies have attempted to measure the problem. Estimates indicate that from 1 to 10% of the elderly population suffers maltreatment. A federal survey estimated that there were about two million cases of elder abuse in family settings during 1989 (Tatara, 1990). Steinmetz found that almost one-quarter of the home care-givers she studied engaged in abusive actions with the potential to severely injure their elderly family member.

Research data clearly indicate that elder abuse is significantly under-identified, much more so than child abuse. The findings of Pillemer and Finkelhor (1988) suggest only one out of every fourteen cases of elder abuse is reported to authorities.

Victims

Any senior can become a victim of elder maltreatment. Early research (Block &, Sinnott, 1979; O'Malley, Segars, Perez, Mitchell, & Knuepful, 1979; Wolf, Godkin, & Pillemer, 1984) found poor females of advanced age suffering physical and mental impairments to be the most likely victims. Pillemer and Finkelhor report that elders in poor health are three to four times more likely to be abused than those in good health,

and that those living with others are more vulnerable to victimization than those living alone. They found males more likely to be abused than females, but the abuse of women to be more serious in nature and consequences.

Kosberg (1988) provides a list of characteristics which place elders at high risk of maltreatment. Included are females of advanced age, those dependent upon others for care, problem drinkers, and individuals with histories of intergenerational conflict. Those who internalize blame, display excessive loyalty towards caregivers, or have suffered abuse in the past are seen as very vulnerable. Also included are those who are isolated or impaired, and who display stoicism or provocative behavior.

Perpetrators

Domestic abuse may be perpetrated by family members or others who reside with the elder. Abuse may also be inflicted by non-residents during visits. Unrelated caregivers constitute a third group of possible abusers. Research has shown that the most common perpetrators of elder maltreatment are spouses and adult children (Pillemer, & Finkelhor, 1988; Ramsey-Klawsnik, 1991; Heisler & Tewksbury, 1991).

Kosberg (1988) provides a list of caregiver characteristics which suggest a high risk of inflicting elder maltreatment. Included are caregivers who are substance abusers, suffer psychological impairment, are economically dependent, and are inexperienced in providing care to others. Additional characteristics are a history of childhood abuse, being unengaged outside of the home, blaming or hypercritical behavior, lacking understanding and sympathy, having unrealistic expectations and being stressed.

Recognizing Elder Maltreatment

Elder maltreatment takes a variety of forms including neglect, financial abuse, psychological abuse, physical abuse and sexual abuse. These will be discussed and indicators of each will be presented. The indicators will assist service providers in recognizing situations of possible or likely maltreatment. Recognition is the first step in stopping abuse and preventing further victimization. The indicator lists have been developed based upon a review of the professional literature and available protocols for assessing elders for maltreatment, as well as the author's clinical and research experience.

Chelucci and Coyle (undated) advise professionals attempting to assess elders for abuse.

> Ask yourself the following key question: "Are the needs of the elderly patient being met?" Do *not* focus on the intentions of the alleged perpetrator. Even those with the best intentions can be abusing or neglecting themselves or others. Our goal is not to assign blame, but to help the patient meet his/her needs.

Neglect & Self-Neglect

Neglect is the deprivation of adequate and timely resources, services or assistance necessary to preserve health and safety. It can result from negligence on the part of caregivers, or be self-inflicted. Opinion differs as to whether self-neglect should be included in formal definitions of elder maltreatment. Adult and elder protective services do intervene in self-neglect cases if the elder accepts services or is deemed incompetent to make judgments in his or her own best interest. Self-neglect can result in serious injury or health problem for elders, therefore it seems appropriate to include this as a form of maltreatment requiring professional recognition and response.

Whether the result of inadequate caregivers or self-inflicted, neglect is often the easiest type of maltreatment to detect. Over time, evidence of neglect shows itself quite visibly and undeniably.

Financial Exploitation

Financial exploitation occurs when an individual confiscates the funds or other material resources of an elder and uses those resources for his or her own purposes, rather than the benefit of the elder.

Heisler and Tewksbury (1991) provide an excellent description and list of indicators of financial and other types of fiduciary

Table 1.
Indicators of Neglect

Symptoms Displayed By the Neglected Elder:
- Malnourishment or dehydration
- Matted, unclean hair
- Bodily crevices caked with dirt
- Presence or odor of old urine, feces
- Oral hygiene unattended
- Overgrown finger/toe nails
- Uncut hair, unshaven
- Improperly clothed (clothing dirty, torn, inadequate)
- Untreated injuries, illnesses, other conditions
- Over or under medicated
- Infestation with fleas, lice
- Isolated for long periods of time
- Poor skin condition / skin breakdown
  - Presence of rash, impetigo, eczema
  - Urine burns, excoriation
  - Presence of decubiti, pressure, or bedsores

Factors Displayed in the Neglected Elder's Environment:
- Dirty, cluttered
- Improper sleeping, cooking, bathing accommodations
- Repairs necessary to maintain health and safety incomplete (i.e., broken windows, exposed wiring)
- Lack of heat, running water, electricity, refrigeration, ventilation, light, sanitation facilities
- Infestation by roaches, rodents
- Presence of too many animals/uncared for animals resulting in health hazard

Elder Experiences Lack of Services and /or Necessary Resources:
- Lack of food, water, fresh air
- Failure to meet special dietary needs
- Necessary medication unavailable
- Lack of medical, dental, nursing, or other therapeutic care
- Lack of eye glasses, dentures, hearing aid. prostheses

Impaired Elder Lacks Required Supervision or Assistance:
- Incapacitated elder left unattended for long periods of time
- Inappropriate caregivers (i.e. too young, incapacitated by substance abuse, mental / physical illness, or handicap)
- Improper means of supervision or use of restraint
- Lack of regular and timely assistance with personal care (bathing, toileting, dressing, eating, ambulation)

(Campbell, 1988; Sengstock & Hwalek, 1985).

abuse of the elderly. They report that while all elders are vulnerable, victims typically are very old, female, unmarried, socially isolated, financially independent, and have significant assets. The perpetrators are often younger male caregivers with emotional problems who are financially dependent upon their victims. They may promise lifelong care in return for signing over assets. Financial abusers often try to isolate their elderly victims, refuse to allow victims to be interviewed alone and lack a true understanding or concern for their victims' well-being.

Mentally impaired elders depending upon others to manage their financial affairs can easily be exploited. As the following case example demonstrates, even seniors competently managing their own affairs can suffer financial abuse perpetrated by others whom they trust to act with integrity.

Illustrative Case

In 1984, 69-year-old Mr. V. felt burdened by his large home. He had difficulty maintaining it, and it felt very empty since his wife's death. He considered selling it and moving to a small condominium, but felt much emotional attachment to the house. His grandson, Charles, was 27, married, and had three young children. He and his wife lived in a two bedroom apartment, and couldn't afford to purchase a house. Mr. V. and his grandson entered into a verbal agreement: He transferred ownership of the house to his grandson at no cost to Charles. In return, Charles promised that Mr. V. would live rent-free in the small apartment downstairs for the remainder of his life. Charles would provide all up-keep and utilities. In 1991, Charles and his wife sold the V. home and used the proceeds as a down payment on a new house. Charles told his grandfather to vacate so that the buyers could take possession. He refused, citing their agreement. Charles served his grandfather with eviction papers. Mr. V. was left with no home and no assets with which to purchase alternative housing.

Psychological Abuse

Psychological abuse (also referred to as

Table 2.
Indicators of Financial Abuse

- Unusual activity in bank or credit card accounts
- Missing pension, stocks, checks, bills, property
- Destruction or removal of bank books or financial records
- New acquaintances expressing affection for an elder
- Lack of amenities when the victim can afford these
- Forged or suspicious signatures
- Failure to deliver services for which payment has been made
- Implausible explanations about elder's financial affairs
- Lack of awareness by the elder about financial arrangements
- Lack of documentation or formal arrangements for care

Table 3.
Indicators of Psychological Abuse

- Self-esteem of elder declines
- Mental health of elder declines
- Fear and/or resentment displayed by elder toward caregiver
- Caregiver verbally or non-verbally manipulates, humiliates, belittles or threatens elder

emotional abuse) occurs when a caregiver injures the elder's self-esteem or inflicts emotional pain. This can be accomplished through verbal means such as insulting, ridiculing, degrading, name calling, yelling, cursing, threatening, being overly critical, or blaming for circumstances not under the elder's control. Nonverbal conduct can also result in feelings of humiliation, shame, or terror. Examples of this are, holding a hammer over the head of an infirmed elder and threatening to strike, withholding a beloved object or pet, or confining an elder to long periods of isolation.

This type of maltreatment, particularly if ongoing, results in victim feelings of inadequacy, guilt, fear, low self-esteem, depression, fear of failure, or fear of not pleasing significant others. The depression and low self-esteem can result in suicidal feelings. Perceptive professionals may observe that psychological abusers display a lack of respect and concern for their elder victim. Although unlikely to engage in severely abusive behavior in the presence of service providers, they often display anger, disdain, and resentment for their elders. These offenders may be observed repeatedly interrupting the elder, ignoring statements made by the elder, referring to the elder in disparaging terms, demonstrating indifference to the elder's emotional needs or describing the elder as an unwanted burden.

Psychological abuse is a concomitant aspect of the two forms of maltreatment yet to be discussed: physical and sexual abuse. These forms of maltreatment are psychologically distressful and often traumatic for the victim, and frequently result in lasting psychological harm. Psychological abuse can also be an integral aspect of neglect and financial abuse, particularly if the elder experiences the neglect or financial abuse as humiliating or otherwise injurious to self-esteem and psychosocial functioning.

Physical Abuse

Physical abuse refers to acts of aggression such as hitting, slapping, punching, kicking, pushing, choking, pinching, shaking, scratching, biting, burning, pulling hair, striking with objects, force feeding or forcing to ingest a noxious substance, use of a weapon to injure, and unreasonable confinement or restraint. Pillemer and Finkelhor studied rates of physical abuse, verbal aggression, and neglect among elders, and found physical violence to be the most widespread.

These indicators should be considered particularly suggestive of physical abuse if the injury is incompatible with the explanation provided or with the medical findings. It is also suggestive of abuse if the caregiver does not seek medical attention for these conditions in a timely fashion or fails to seek treatment altogether. A caregiver report of the elder as "accident prone" should be viewed with suspicion. A caregiver and/

Table 4.
Indicators of Physical Abuse

Physical Indicators:
- Bruises, welts, lacerations scratches, abrasions
- Bleeding
- Human bite marks
- Bilateral bruises on forearms suggesting shaking
- Imprint injuries (marks shaped like fingers, thumbs, hands, belts, sticks, rulers)
- Burns (especially inflicted by cigarettes, matches, ropes, irons immersion in hot water)
- Gag marks
- Sprains, dislocations, fractures
- Spotty balding from pulling of hair
- Punctures
- Eye injuries (black eye, red eye, detached retina)
- Missing teeth
- Unexplained scars
- Internal injuries

Psychosocial Indicators:
- Post-Traumatic Stress Disorder
- Fear, anxiety, mistrust
- Shame, humiliation
- Strong ambivalent feelings towards beloved other

or elder who fails to consistently utilize the services of one primary physician or hospital may be attempting to hide evidence of physical abuse. An unusual pattern of injuries, repeated injuries, injuries at various stages of healing, and injuries to unlikely areas of the body should be viewed as suspicious for physical abuse.

Victims may display psychosocial indicators of their physical abuse. Symptoms associated with Post Traumatic Stress Disorder may be seen, including: reexperiencing the trauma through nightmares or intrusive thoughts about the abuse; numbing of responsiveness through markedly diminished interest in significant activities; or intensification of symptoms by exposure to events that symbolize the trauma (APA, 1987). The victim may express fear through flinching or overly compliant behavior. Ambivalent feelings are common in victims of domestic abuse who may love, but at the same time fear and hate their offenders.

Sexual Abuse

Sexual abuse occurs when an individual is forced into unwanted sexual contact. Victims may be physically forced, emotionally intimidated, manipulated or otherwise coerced into sexual activity. Sexual abuse also occurs if an elder is incapacitated by a mental or physical impairment, and thus unable to grant informed consent at the time of sexual activity. A continuum of sexually abusive behavior exists (Ramsey-Klawsnik, 1991). Covert abuse includes activity such as sexual harassment and threats. Elders forced to view pornographic material or the exhibitionistic behavior of others constitutes more overt abuse. Sexual abuse may involve physically intrusive acts in which the offender molests the elder orally, vaginally, or anally rapes the elder with a penis, fingers, or objects; or forces the victim to perform sexual acts on the perpetrator. Extreme cases involve allowing others sexual access to elders through swapping or prostituting.

Sexual offenders are attracted by vulnerability and availability, rather than by the physical attributes of potential victims (Groth, 1979). Individuals wishing to sexually abuse need access to others who will serve as desirable victims, that is, those who are readily available, easy to intimidate and overpower, and lack credibility. For these reasons, impaired elders are vulnerable to sexual abuse.

Many are surprised to learn that elders, as well as children, can be victims of sexual abuse perpetrated by family members and caregivers. Only in recent years has this form of elder maltreatment been formally identified. Fifty-two cases of suspected elder sexual abuse perpetrated by family members and other caregivers have been identified in Massachusetts (Ramsey-Klawsnik, 1991). Other cases have been substantiated by adult protective services in most states across the nation. In addition, a

study underway in England has revealed 90 cases of domestic elder sexual abuse (Holt & Ramsey-Klawsnik, In Press) perpetrated by family members. Due to the recent identification of this problem, most of the professional literature and training regarding elder maltreatment has inadequately addressed this serious form of abuse.

Sexual abuse should be suspected if an individual displays irritation, injury, infection, bruising, bleeding, or other trauma about the genitals, mouth, or anal areas. Injury to other parts of the body may also signal sexual abuse. During sexual assault offenders may injure the face, arms, legs, neck, buttocks, or other areas by violently restraining the victim or by physically assaulting them.

The psychosocial indicators of trauma discussed in relation to physical abuse are also exhibited by many sexual abuse victims. They frequently (but not always) display fear of and suspicion toward their offenders. This fear and suspicion may extend to others who are similar to the offender.

Multifaceted Abuse

In many cases, abuse is multifaceted in that several forms of victimization occur simultaneously. In the following case example, the victim experienced physical, sexual and psychological abuse.

Illustrative Case

Mrs. S. is a 73-year-old bedridden stroke victim. She resides at home, her husband is her primary caregiver. Visiting nurse and home health aide services were arranged at the time of her hospital discharge. During home visits, service providers found that Mrs. S. suffered recurrent, unexplained vaginal bleeding. She also experienced marks on her wrists and ankles of puzzling origin. When questioned about these symptoms, Mrs. S. became upset, but failed to provide an explanation. The visiting nurse reported suspected abuse of Mrs. S. to Elder Protective Services. During interviews conducted by a social worker, Mrs. S. revealed that several times weekly Mr. S. tied her wrists and ankles to the hospital bed and vaginally raped her. The assaults sometimes lasted for as long as an hour. The social worker attempted to persuade Mrs. S. to move to a nursing home. The woman tearfully refused, and the sexual abuse continued. It was subsequently learned that Mr. S. had threatened that if Mrs. S. did not remain with him and tolerate his actions, he would rape the couple's two granddaughters, ages six and eight years.

Table 5.
Indicators of Sexual Abuse

- Trauma about the genitals, rectum, mouth
(Bruising, bleeding, injury, infection, scarring, redness, irritation, pain)
- Presence of sexually transmitted disease
(Particularly if the elder is not engaged in consenting sexual activity)
- Injury to the face, neck, chest, abdomen, thighs, buttocks
- Psychosocial indicators
  - Post-Traumatic Stress Disorder
  - Fear, anxiety, mistrust
  - Shame, humiliation
  - Strong ambivalent feelings towards beloved other

Extreme upset when bathed, toileted, changed

Responding to Elder Maltreatment

Clinicians specializing in elder abuse intervention have observed that it tends to escalate in incidence and severity over time. It is therefore critical that service providers act to alleviate maltreatment which comes to their attention, and thereby prevent further, perhaps more serious harm. In 43 states and the District of Columbia, professionals and many paraprofessionals are legally required to report suspicions of elder maltreatment to Elder or Adult Protective Services (Johnson, 1991). Most states offer immunity from civil or criminal liability to professionals and others making a report in good faith. Concerned providers need not have proof that maltreatment has occurred in order to report. The purpose of a report is to initiate an investigation into the care and condition

of the elder in question, and ultimately to provide protection and safety to maltreated elders. The few states which do not mandate reporting do have provisions for receiving and investigating suspected elder maltreatment cases and encourage reports.

Elder service providers should suspect maltreatment in two situations: (1) a client voluntarily discloses abuse or neglect or (2) indicators of maltreatment are observed.

Responding to Volunteered Disclosures

Disclosures of maltreatment may be offered in the context of a trusting relationship with a supportive service provider. The disclosure may be "coded" (i.e. "You wouldn't believe the nasty things my son does"), or may be a clear and direct statement (i.e. "I'm afraid of my son, when he's drunk he hurts me"). If an elder volunteers that she or he has been maltreated, professionals and paraprofessionals should respond with kind acceptance. It is important not to over or under react. Avoid expressing personal feelings of anger, shock, disbelief, etc. This is not helpful, but may, in fact, cause the victim to refrain from providing further information. An appropriate response is to express regret that the client has been mistreated, and to invite the individual to continue talking about this if desired. One should convey that the victim is an important person who deserves to be well-treated. It can also be helpful to state that other elders suffer maltreatment, and that abuse is not the result of the victim's actions. One must refrain from promising confidentiality about the maltreatment. It is suggested that the client be informed that the information will be shared with certain key others who will work to insure the elder's safety and well-being.

Service providers should not conduct a formal maltreatment interview if they have not been trained to do this, and if their job description does not include this task. Asking the detailed and specific questions necessary in a formal investigation requires considerable training and knowledge of the legal as well as clinical issues involved. Individuals specifically trained and required to interview will need to proceed with caution and care (Ramsey-Klawsnik, 1993).

Following the disclosure, immediately document the interaction with detailed notes. Specify what was said and/or demonstrated non-verbally by the victim. Report this information to protective services without delay. If the abuse poses a serious danger to the victim's health or safety, it is particularly important to report immediately, and to request an immediate response from state authorities. Immediate response is also critical if physical evidence of maltreatment is present.

Responding to Evidence of Maltreatment

In the course of service provision, one may encounter evidence of maltreatment in the absence of any disclosed abuse on the part of the patient. Many abused elders realize that the treatment they endure is not right, but do not know that elder abuse is against the law and that they do have rights. Abused elderly persons may be unfamiliar with the services that exist to help them to safety. Victims may fear that services will be forced upon them against their will, and that the solution will be worse than the problem. A sense of loyalty inhibits many victims of family abuse from telling others about their offenders' hurtful behavior. Some victims do not have access to a telephone, or other means of summoning assistance. Elders suffering significant physical and/or mental impairment may not have the capability to independently seek help. They must rely upon caring and concerned others to recognize danger signals and offer assistance.

The presence of indicators does not prove the existence of elder maltreatment, since factors other than abuse may account for the symptoms. Indicators suggest the possibility of maltreatment, particularly if a constellation of symptoms are present, if they are recurrent, or if they are present over time. Under most circumstances, careful professional interviewing and investigation are required to determine whether or not maltreatment has occurred.

Service providers observing symptoms of abuse should ask about these in a supportive manner. Obviously, asking a victim about injuries or other evidence in the presence of the abuser is likely to lead to denial of maltreatment, and may jeopardize the victim's future safety. What may be less obvious is that sometimes a family member or caregiver who appears to be loving and supportive may be an abuser. The safest practice is to ask the elder about the symptoms privately. A victim may acknowledge abuse when asked about symptoms in a safe and supportive environment. In the event this occurs, providers should handle the disclosure as discussed above.

If questioning a suspected victim is impossible (for example, the patient is comatose), indicators of maltreatment should be reported to state authorities for investigation.

When a professional explores the possibility of maltreatment with a verbal victim, the elder may deny abuse, but respond in a manner which gives rise to further concerns. For example, the victim may display fear, upset, anxiety, or sadness. Providers should report these situations for investigation.

During an investigation, service providers should be prepared to meet with the investigating social worker to share professional findings, observations, and impressions pertinent to the elder's health, welfare, safety, and over-all condition.

If it is determined that an elder has suffered abuse or neglect, protective services will offer assistance to that individual. Protective services cannot force intervention upon legally competent victims who decline assistance. In the case of elders who decline intervention but are believed to be incompetent to make decisions in their own best interest, legal proceedings will be initiated to determine the client's competence, needs, and the best method for insuring these needs are met.

A variety of casework interventions and services are available for maltreated elders. These are designed to limit the dependency upon the abuser, to prevent further abuse or neglect, and to insure the victim's health, safety and recovery from maltreatment (Breckman & Adelman, 1988).

All seniors deserve to have their basic needs met in safe, comfortable, non-violent environments. Professionals and paraprofessionals serving elders have a key role to play in identifying situations symptomatic of maltreatment, and taking steps to insure that these are investigated and appropriate services are provided.

Note

[1] *This and other illustrative cases are composites based upon elder maltreatment cases referred to the author for clinical consultation. All identifying information has been changed to protect the confidentiality of the victims.*

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Elder Sexual Abuse: Preliminary Findings

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ABSTRACT. Twenty-eight cases of suspected elder sexual abuse were identified and described by elder protective service workers. All the victims were female, and 71% experienced significant limitations in capacity for independent functioning and self-protection. Indicators of sexual abuse included victim self-report and third party observation of assault, physical injury, and psychosocial symptoms. All but one of the suspected offenders were male. Eighty-one percent were caregivers for the women they allegedly assaulted, and 78% were family members, predominantly sons and husbands. Repeated vaginal rape was the most prevalent type of reported assault. Findings of the study are presented, and issues relative to the sexual victimization of elders are discussed.

Intrafamilial abuse and neglect have rightfully attracted society's attention. Recognition that older people are frequently victims has resulted in research, practice, and legislative attention to elder maltreatment. Although no generally accepted definition of elder abuse and neglect exists (Pillemer & Finkelhor, 1988; Kosberg, 1988), usual definitions include some or all of the following: physical abuse, emotional or psychological abuse, financial or material exploitation, and active and passive neglect (for example, Block &

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Sinnott, 1979; Douglass et al., 1980; Pedrick-Cornell & Gelles, 1982; Pillemer & Finkelhor, 1988). Intrafamilial violence towards wives and children is considered to encompass all of these forms of maltreatment and, in addition, sexual abuse. During recent years the sexual abuse of wives and children has received considerable attention while, in contrast, that of elders has received little public or professional recognition.

A literature search revealed only three articles specifically addressing elder sexual abuse. Groth (1978) reports twenty-two cases of elder rape. The majority of these victims did not know their assailants. Reay and Eisele (1983) describe one case of the sexual abuse and murder of an elderly woman by an unrelated acquaintance. Cartwright and Moore (1989) report twenty-one cases of stranger-rape of women between the ages of sixty and ninety. These accounts focus on the sexual assault of elders by strangers rather than by family members in caregiving roles.

The literature contains few references to elder sexual abuse by family members and other caregivers. Some authors include sexual abuse as a form of elder physical abuse (Douglass et al., 1980; Sengstock & Hwalek, 1985; Wolf et al., 1984). Wolf and colleagues indicate that three of the 328 cases of elder abuse and neglect they studied involved sexual molestation. O'Malley (1979) lists sexual abuse as a type of elder abuse distinct from physical abuse but does not address the problem. Chen et al. (1981) and St. Vincent Medical Center (1985) identify sexual abuse as a form of elder maltreatment but limit their definition to rape and attempted rape, excluding other forms of sexual abuse such as exhibitionism and molestation. Other references to elder sexual abuse are sparse. Kosberg (1988) mentions that elder women are more vulnerable than men to sexual molestation. Campbell (1988) includes sexual abuse/assault as a type of elder abuse and provides a list of seven physical indicators of possible sexual abuse. Halamandaris (1986) discusses a year long investigation of elder abuse, including sexual abuse, by the House Select Committee on Aging. One illustrative case is offered involving a twenty-two year old male who physically and sexually assaulted his elderly grandmother. Notably absent from the literature is research about investigating elder sexual abuse investigation. Despite the lack of formal study, protective service

workers are encountering elder sexual abuse and expressing a need for training on the topic. A request for information on elder sexual abuse was made by the Massachusetts Executive Office of Elder Affairs. In response, an exploratory study was undertaken.

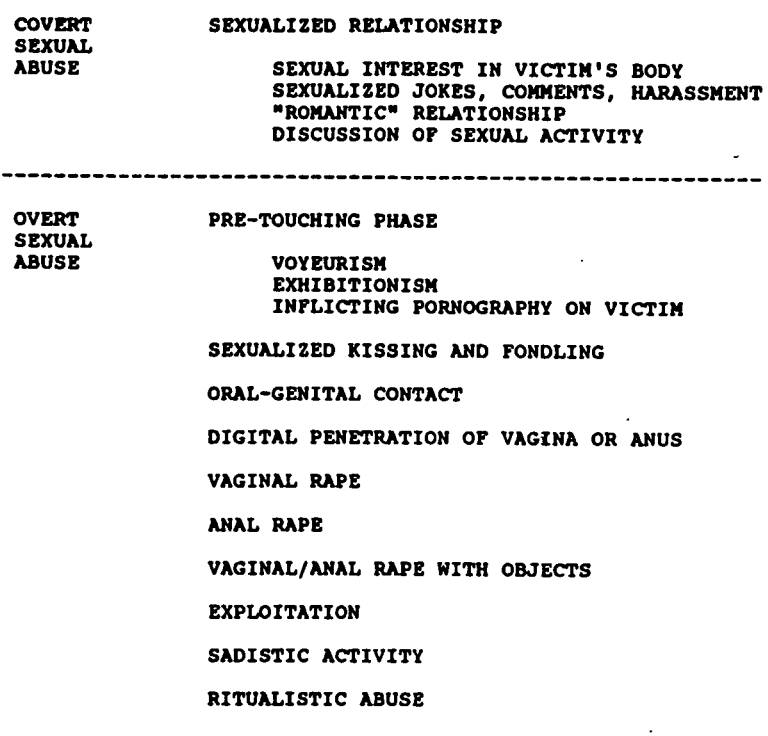
METHOD

Elder protective service workers and supervisors who attended the 1989 annual Massachusetts Elder Affairs Conference and Recognition Day were queried concerning their experience with cases of suspected elder sexual abuse. A total of twenty-eight cases of suspected elder sexual abuse were reported and described. (A second wave of data-collection during the 1990 conference yielded thirty-two additional cases. This data is presently undergoing analysis.) The staff who were surveyed work with elders residing in the community. Since they are not responsible for serving elders abused in nursing homes and other institutional settings, this study did not screen for institutional sexual abuse of elders.

During the first data-collection period, questionnaires were administered to twenty workers and supervisors who attended an elder sexual abuse training workshop. Questionnaires were completed during the workshop, following a presentation of the range and types of behaviors which constitute sexual abuse and common signs and symptoms indicative of possible sexual abuse. The Sexual Abuse Continuum presented in Figure 1 was utilized to delineate the range and types of sexually abusive behaviors addressed in the study.

The continuum was developed based upon research and clinical findings (Groth, 1979; MacFarlane & Waterman, 1986; Mayer, 1983; Russel, 1990; Sgroi, 1982) and the author's extensive experience interviewing child and adult victims of sexual violence. The continuum presents the activities typically described by victims during their reports of sexual abuse. The activities are listed in rank order from (generally) least to most severe in terms of degree of violence and trauma to the victim. Sexual abuse often begins with activities in the less severe range and escalates over time to more severe types of abuse. To constitute sexual abuse, the recipient

FIGURE 1. Sexual Abuse Continuum



would have been forced, tricked, threatened, or otherwise coerced into the sexual contact against his or her will.

Covert sexual abuse does not mean sexual contact between offender and victim, but rather, involves an offender who treats the victim as a sex object and/or as a potential sex partner. (See Herman, 1981, for a further description of covert sexual abuse.) Sexual harassment, inappropriate comments, and threats are examples of this behavior.

The pre-touching phase of overt sexual abuse involves use of the victim for voyeuristic purposes, the offender exposing himself or others to the victim and forcing the victim to view pornographic materials. Activities ranging from sexualized kissing and touching the victim to rape with objects are self-explanatory. Exploitation encompasses situations in which the offender gains something illicit

in addition to sexual contact from the victim. Examples would be "swapping" the victim with another offender, prostituting the victim, or using the victim to produce pornography. Sadistic activity includes situations in which the offender gains erotic pleasure through the deliberate infliction of physical pain upon the victim during the sexual assault. Sadistic offenders may burn, beat, tie or otherwise physically torture victims during the sexual assault. Ritualistic abuse is a severe form of maltreatment which involves repetitive and often sadistic sexual, physical, and psychological assault usually perpetrated by multiple offenders acting in concert (Hudson, 1989; Kelley, 1988; Ritual Abuse Task Force, 1989). This continuum was discussed with the questionnaire respondents as was the list of signs and symptoms of possible sexual abuse that are presented in Figure 2.

Many of these signs and symptoms are also indicative of problems other than sexual victimization. The presence of one or more

FIGURE 2. Signs and Symptoms of Possible Sexual Abuse

Genital or Urinary Irritation, Injury, Infection or Scarring

Presence of a Sexually Transmitted Disease

Frequent, Unexplained Physical Illness

Intense Fear Reaction to an Individual or to People in General

Mistrust of Others

Nightmares, Night Terrors, Sleep Disturbances

Phobic Behavior

Extreme Upset When changed or Bathed

Regressive Behaviors

Aggressive Behaviors

Direct or Coded Disclosure of Sexual Abuse

Disturbed Peer Interactions

Depression or Blunted Affect

Poor Self-Esteem

Self-Destructive Activity or Suicidal Ideation

of these does not prove the existence of sexual abuse. A pattern of indicators would suggest the possibility of sexual victimization, however, and should lead protective workers to screen for possible sexual abuse.

Following presentation of the continuum and signs and symptoms, participants were asked to complete the questionnaires. Their instructions were to report all cases in which they suspected an elderly client had experienced (at age sixty or over) any abusive acts listed on the continuum. To insure the reported cases were mutually exclusive, supervisors were instructed to only report cases if the worker who had serviced the case was not present to provide data. Workers were instructed to avoid duplicate reporting in the event that two or more workers who had serviced the same suspected sexual abuse victim were among the group of respondents. Workers and supervisors were provided time to confer regarding the reporting of shared cases.

Questionnaires were completed by twenty workshop participants. Seventy-five percent indicated they had serviced one or more victims of suspected elder sexual abuse, and over half had serviced more than one. These respondents were asked to provide, to the best of their knowledge and recollection, a variety of case specifics regarding the client, nature and extent of the suspected sexual abuse, factors leading to suspicions, and the alleged offender. Respondents were also invited to write comments on the questionnaires and to add comments during a discussion following completion of the questionnaire.

RESULTS

Suspected Victims and Sexual Victimization

All twenty-eight suspected elder sexual abuse victims were females. Their ages ranged from sixty-five to one hundred and one. Forty-six percent were in their 70s and 21% in their 80s. These women were quite limited in their capacity to protect and care for themselves. The majority (71%) were described as "totally dependent" or functioning "very poorly" or "poorly." Twelve of these women were described by their protective workers as suffering se-

vere psychiatric impairments, three had Alzheimer's disease, two were mentally retarded, four were bedridden, and one was an aphasic stroke patient.

Questionnaire respondents were asked to describe the nature and extent of sexual abuse to the best of their knowledge. As can be seen from Table 1, allegations ranged the gamut of the sexual abuse continuum from covert activities to ritualistic abuse. In 61% of the cases, rape was suspected. Repeated vaginal rape was the most commonly reported type of assault. In three cases, more than one activity was reported. The suspected ritualistic victim was assaulted by a male and a female caregiver to whom she was unrelated. She suffered multifaceted sadistic assault which included being tied and burned on numerous areas of her body.

Factors Leading to Suspicion of Sexual Abuse

Table 2 presents the factors which led to the suspicion of sexual abuse. In almost one-third of the cases, sexually abusive acts towards elders were actually witnessed by others. The observers included family members, home health aides and nursing staff, protective service workers, and a neighbor. In one case, multiple service providers repeatedly observed an adult son engage in open mouth kissing of his elderly mother which lasted for many minutes.

TABLE 1. Suspected Elder Sexual Abuse Activities (N = 28)

ACTIVITY	# OF SUSPECTED VICTIMS
Repeated vaginal rape	10
Sexualized kissing/fondling	5
Voyeurism/exhibitionism	3
Vaginal rape (single episode)	3
Vaginal rape with objects	3
Subjecting to pornographic films	2
Oral-genital contact	1
Anal rape with objects	1
Ritualistic abuse	1

Note: in 3 cases multiple activities were reported.

TABLE 2. Factors Leading to Suspicions of Elder Sexual Abuse (N = 28)

FACTORS	# OF SUSPECTED VICTIMS
Physical injury	10
Third party observation of sexual abuse	9
Victim's disclosure of sexual abuse	8
Psycho-social symptoms	8
Suspected offender's observed behavior	7
Victim's coded disclosure of sexual abuse	2

Note: In 57% of the cases, multiple indicators were reported.

Witnessed abuse also included acts at the more severe end of the continuum. For example, a violent vaginal rape was observed by a concerned neighbor who came running upon hearing the screams of the victim.

Nine elderly victims disclosed sexual abuse to a service-provider or confidant. Two additional women made coded disclosure or hinted that they had been sexually abused. Because the humiliation typically experienced by sexual abuse victims tends to inhibit disclosure, it is not unusual for victims to deny ongoing abuse, or to make only coded, rather than direct disclosure.

Physical injuries reported included: repeated vaginal infections, bleeding, tearing; genital scarring; burns; and prolapsed uterus. (While there may be many causes of a prolapsed uterus in an elderly woman which are unrelated to sexual abuse, this condition in one woman, coupled with other medical evidence, caused the worker to suspect sexual abuse. Prolapsed rectums have occasionally been diagnosed in children who have been violently and repeatedly anally raped.) Psychosocial symptoms such as fear, anxiety, and mistrust of specific others were observed and reported by the protective service workers. Suspected offenders' observed behavior included alcoholism, reluctance to allow others access to the woman for whom they provided care, and comments conveying perceptions of the elder as sexual property. For example, in one case a husband caring for his bedridden wife did not clothe the woman but instead had her

lie undressed beneath the bedclothes. He expressed to the worker that this made it easier to "get at her."

In 57% of the cases (N = 16), multiple indicators were reported. For example, one woman experienced significant vaginal tears and bleeding. The caregiver was her alcoholic son with whom she resided. In another case, a mute Alzheimer patient who exhibited genital scars resided with and was cared for by her brother. She was observed backing away and screaming in evident fear when he entered her room. It is noteworthy that he had refused outside caretaking for this woman. In 71% of the cases (N = 20), other service providers (in addition to the workers) also had suspicions of sexual abuse which had been conveyed to the worker.

Suspected Offenders

Except in one case, specific individuals were identified as the suspected perpetrators, twenty-six cases indicating a male offender, and in another case a male and female caregiver were the most likely perpetrators. In 81% of the cases, the suspected offenders were caregivers, and 78% were family members (primarily sons and husbands). Over half of the cases constitute incest. Table 3 presents the relationships of suspected offenders to victims.

Ages of suspected offenders ranged from twenty-two (the grandson) to eighty-eight. Twenty-one percent were under age forty.

TABLE 3. Relationship of Suspected Offenders to Victims (N = 28)

RELATIONSHIP	# OF SUSPECTED VICTIMS
Husband	7
Boyfriend	1
Son	11
Grandson	1
Brother	2
Boarder	2
Friend	1
Distant relative	1
Unrelated caregiver	2

Forty-three percent were age forty to sixty, primarily the sons of victims. Over one-third (36%) of the suspected offenders were themselves elders. Seven were in their sixties and seventies, and three were in their eighties. These men were the husbands, boyfriend, and brothers of victims. The elder offenders were healthier and physically stronger than their victims and served as their caregivers.

Reactions of Respondents

Many respondents made comments in the space provided on the questionnaire. Several reported that, only in retrospect, they recognized some of their previous clients as victims of elder sexual abuse. For example, one worker discussed a client who had been repeatedly subjected to pornographic film-viewing. The offender was her son who propped the immobile woman in front of the television for hours at a time and showed X-rated videos. The only available escape for this woman was sleeping, and she frequently expressed disgust and displeasure about viewing the films. The worker commented, "I knew that was wrong and I felt very upset about it. I didn't know it was sexual abuse but I didn't feel empowered to stop it."

Workers discussed other situations in which they believed abusive sexual activity was forced upon their elderly clients, while they as workers felt powerless to intervene. They expressed frustration about not knowing how to interview clients for possible sexual abuse, as well as the lack of training and literature on the subject. Workers reported feeling hampered in their attempts to help sexually abused elders by ignorance on the part of other professionals who down-played or ignored their concerns. They also cited elder abuse legislation which does not specifically address sexual abuse as handicapping them in their protection efforts.

DISCUSSION

The most typical picture of the elder sexual abuse victim which emerged from this preliminary study is of a woman, in her seventies, suffering major impediments to self-care. She is dependent upon another for care and is sexually assaulted by that person. The

abuser is male, likely a grown son or husband. The sexual abuse consists of repeated vaginal rape, probably accompanied by other forms of molestation. She is receiving elder protective services for another form of maltreatment. In the course of service-delivery her worker comes to suspect possible sexual abuse due to a constellation of symptoms. The worker has had no formal training in interviewing or treating sexual abuse victims. She receives little support or guidance from other professionals in exploring these concerns and feels helpless to help the client.

The degree to which this picture is representative of sexually abused elders is impossible to determine from this exploratory effort. The study utilized a small, non-random clinical sample consisting of sexual abuse cases identified primarily as a result of protective service involvement for other maltreatment concerns. The findings, are therefore, not generalizable. A further problem with the methodology is the reliance upon worker memory, rather than written records. The protective service staff who provided the data may not be representative of their peers. Although seventy-five percent of them had experience with suspected elder sex abuse cases, it is likely that workers who had encountered the problem were attracted to the Elder Sexual Abuse Workshop. A further limitation is the lack of information provided directly from suspected victims.

Despite the limitations, this study demonstrates that elder sexual abuse by family members and caregivers does occur and requires recognition, intervention, and scientific investigation. Kosberg (1988) and Finkelhor and Yllo (1983) have pointed out the value of exploratory research which describes a previously unstudied problem and outlines issues for further inquiry. Exploratory studies raise more questions than they answer. Future research should address a number of questions. Why does elder sexual abuse occur? How prevalent is it? In what ways is it similar to and different from other forms of elder abuse and family violence? Who are the victims and perpetrators? What intervention is required?

Why Elder Sexual Abuse?

Early research on elder physical and emotional abuse and neglect found that victims tend to be female, very old, and physically and mentally impaired (Block & Sinnott, 1979; Lau & Kosberg, 1978;

O'Malley, 1979). The victims in the Wolf et al. (1984) study were typically female, about 75 years old, and physically and mentally impaired. They were most often abused by younger live-in males who depended financially upon the elder. Kosberg (1988) provides a list of twelve characteristics which make elders particularly vulnerable to abuse. These include being female, of advanced age, dependent, impaired, and having a history of intergenerational conflict and past abuse. Pillemer and Finkelhor (1988) found elders in poor health and living with others to be at highest risk of abuse. Contrary to earlier studies, they report males twice as likely as females to be abused. Elder abuse against men was disclosed to be less serious than that against women, and the women reported suffering more physical and psychological consequences of abuse than did the men.

Females are predisposed to victimization due to the greater physical, social, political, and financial power generally held by males. Old age and impairment decrease personal power and thereby increase the risk of abuse. It is not physical attributes, but rather vulnerability, which attracts a sexual offender (Groth, 1979). Elderly, impaired individuals make excellent sex abuse victims, precisely because of their inherent vulnerability. Speech and language deficits are common in the geriatric population, especially in the stroke patient. These people are at even greater risk of sexual abuse due to their inability to disclose victimization. Elders capable of verbal disclosure are not immune from abuse. Those experiencing short-term memory loss, dementia, and other mental impairments often lack credibility. Their disclosures of sexual abuse may be discounted. Any factor which decreases an individual's credibility also increases vulnerability to abuse. Consequently, elderly, disabled females make excellent sexual abuse victims.

Victims and Perpetrators

Spouses As Sexual Offenders. Twenty-nine percent of the studied cases appear to be situations of marital rape and/or other forms of sexual abuse by mates (seven husbands and one boyfriend were the reported offenders). It is unknown if their victims experienced sexual abuse throughout the relationships, or if the abuse began when

the women became ill, infirm, and dependent. Russell (1990) reports that 14% of all married women have experienced completed or attempted marital rape and that this is the most prevalent form of rape. Marital rape typically begins early in the life of the woman, as well as early in the development of the relationship (Russell, 1990; Douglass, 1987). This suggests the possibility that some or all of these women experienced sexual abuse throughout the marriage. Future research on elder sexual abuse should include interviewing victims. One of the areas of inquiry for marital victims should be the duration of abuse and conditions under which onset occurred.

For generations, women have been socialized to believe that it is their duty as wives to perform sexually for their husbands upon demand. Until the mid 1970s, this norm was sanctioned by laws which exempted men from any legal consequences for forcing themselves sexually upon their wives. Criminalization of marital rape in most states represents significant progress away from the view of women as the property of their husbands. As of March, 1991 forty-four states had criminalized marital rape (Schulman et al., 1990; X, 1991). Older women who have been married for many years lived for long periods of time (conceivably as long as thirty to forty years) without legal protection from sexual exploitation by their husbands. These women, believing that they have no alternative, may be more likely than younger women to endure spousal sexual abuse.

Among the forty-four states which have criminalized marital rape, thirteen exclude husbands from prosecution if their wives suffer from a temporary or permanent mental or physical disability (Schulman, 1990; X, 1991). These exclusions potentially have serious ramifications for elderly married women who develop impairments, leaving them legally vulnerable to sexual exploitation by their husbands.

The finding that almost a third of the sex offenders were spouses is consistent with other research results. Studies investigating other forms of elder abuse have revealed that a significant percentage of abusers are spouses. Wolf et al. (1984) report that 23% of the elder offenders they studied were spouses (husbands and wives). O'Malley et al. (1979) found 20% of elder abusers were husbands. Pillemer and Finkelhor (1988) found that 58% of the elder abusers in

their survey were spouses, and 22% were husbands. They report that elder abuse perpetrated by spouses is incorrectly considered less serious and dangerous than that perpetrated by adult children, but the level of violence inflicted by spouse perpetrators and adult child perpetrators was about equal. Similarly, there has been a popular belief that marital rape is less traumatic than assault by non-intimates. Russell (1990) and Finkelhor and Yllo (1983) found marital rape to be more traumatic than rape by others. These findings suggest that sexual abuse of elderly women by their husbands is likely violent and traumatic and requires the serious attention of professionals serving abused elders.

Pillemer and Finkelhor (1988) conclude that elder abuse has much more in common with spouse abuse than child abuse and that spouse abuse has basically been ignored by those concerned with elder abuse. Wolf et al. (1984) also found that elder physical abuse is similar to spouse abuse, typically involving two relatively independent people sharing a residence with the stronger abusing the weaker. These findings indicate that elder protective service workers require training about physical and sexual spouse abuse, including dynamics, indicators, interviewing methods, and intervention strategies. Pillemer and Finkelhor (1988) have also suggested similar education of elder service providers.

Sons As Sexual Offenders. The largest category (over 39%) of suspected offenders were sons believed to be sexually abusing their elderly mothers. This is a much larger percentage than has been reported in studies investigating other forms of elder abuse and neglect. Pillemer and Finkelhor (1988) found 16% of elder abusers are sons. Sons engaging in elder sexual abuse may be qualitatively different from those engaging in other forms of elder mistreatment. Further research in this area is required.

Significant questions arise in regard to this form of incest. Why would a grown son sexually assault his elderly mother? Do men who rape their mothers also rape other women? Was incest a formative experience in the childhoods of these men? Did they suffer early abuse by their mothers or other caretakers? Cartwright and Moore (1989) conclude that elder rape by younger men is motivated by anger and desire for power over the victim. Groth (1978) suggests an elder rape victim may symbolize an authority figure over

whom the offender desires power. She may or may not be the actual woman against whom he wants to retaliate. Further research is needed, including qualitative study of the victims and their assailants, to understand the dynamic of son-mother sexual assault.

Interestingly, all of the victims in this study were female and almost all of the perpetrators male. This finding is consistent with the trend noted by Wolf and colleagues (1984) that "As the evidence mounts, elder abuse comes more and more to look like other social problems: violence against women carried out predominantly by men." It is also consistent with statistics regarding child sexual abuse victims and perpetrators (Finkelhor, 1984). In all probability, women are predominately the victims and men the perpetrators of elder sexual abuse. However, the possibility of male victimization and female perpetration should not be disregarded.

Incidence and Prevalence

The extent of elder sexual abuse is unknown. The methodology of this study does not permit drawing inferences regarding prevalence. Pillemer and Finkelhor (1988) estimate the prevalence of elder abuse and neglect, exclusive of sexual abuse, to be 32 maltreated elders per 1000. Including sexual abuse in the definition of elder abuse and neglect may yield a higher prevalence rate. The lack of formal attention thus far attracted by elder sexual abuse might suggest that it is a rarely occurring phenomenon. Child sexual abuse, marital rape, and other forms of family violence were also considered rare prior to identification and research by the scientific community. Prevalence studies must research sexual abuse as a separate and distinct category of elder abuse and neglect. In addition, future studies addressing the broad range of behaviors constituting elder abuse and neglect should include investigation of sexual abuse.

Policy and Practice Implications

Sexual assault of dependent elders by family members and caregivers is alarming and distasteful, and, therefore, difficult to acknowledge. However acknowledgement is the first step towards ameliorating a problem. Because elder sexual abuse has been over-

looked by policy-makers and practitioners, legislative and intervention initiatives are required.

Pedrick-Cornell and Gelles (1982) discuss the dangers of legislation and intervention strategies hastily enacted upon discovery of previously overlooked social problems. Bolton and Bolton (1987), Clark-Daniels et al. (1989), Daniels et al. (1989), Fredriksen (1989), Faulkner (1982), and Kosberg (1988) have discussed the potential negative consequences of addressing elder abuse by adopting child abuse legislation and intervention strategies, particularly mandatory reporting. Arguments against mandatory reporting include the belief that the policy treats elders like children and is an intrusion into privacy. The possibility of overwhelming the capacity of the system for investigation and service-delivery is also cited as a reason against requiring professionals to report suspected elder abuse. Daniels et al. (1989) urge that adequate resources be allocated for investigation and intervention following mandatory reporting of elder abuse cases. They argue that abolishing mandatory reporting of suspected cases of elder abuse and neglect will result in burying the problem.

Forty-two states and three jurisdictions have adapted legislation requiring professionals to report cases of suspected elder abuse and neglect (Tatara, 1990). Just as the words "sexual abuse" have been excluded from most definitions of elder maltreatment, they have similarly been largely omitted from mandated reporting and other legislation addressing elder abuse. Mandated reporting is an appropriate method for identifying abused elders who are unable to protect themselves and/or unable to independently seek help due to disabilities. Sexual abuse should be specifically included in definitions of elder abuse and neglect cited in mandatory reporting and other elder abuse legislation.

Elder protective service staff should be trained to identify the signs and symptoms of sexual abuse and to recognize the types of activities which constitute sexual abuse. They further require training and supervised practice in methods of interviewing and treating victims. Successful intervention into elder sexual abuse requires acknowledgment of the problem, professional training in case identification and service-delivery, and legislation to promote the reporting, investigation, and treatment of cases.

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Interviewing Elders for Suspected Sexual Abuse: Guidelines and Techniques

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ABSTRACT. There is little professional literature, research, or training regarding elder sexual abuse, despite the fact that cases are being identified in many locales. This article presents guidelines and techniques for identifying and interviewing possible elder victims of sexual abuse. Signs and symptoms of sexual abuse are provided and the variety of sexually abusive behaviors is delineated. Guidelines are presented regarding who should conduct interviews, the location and setting, and rapport-building. The range and nature of focused questioning are examined. Examples are provided of non-leading, open-ended questions designed to screen for sexual abuse. Specific techniques are illustrated for working with non-verbal elders. Intervention strategies are suggested for cases in which sexual abuse has been substantiated.

Physical abuse, emotional abuse, neglect, and financial exploitation of the elderly have been identified as problems since the late 1970s. Recently, professionals serving elders have also identified cases of sexual abuse, although the prevalence of this abuse has not been established. While cases of elder sexual victimization are being documented, little research, literature, or training on elder sexu-

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al abuse exists. Recently, however, the author has published a study of 28 cases identified by Massachusetts elder protective service workers (Ramsey-Klawsnik, 1991). The second-wave of data collection in Massachusetts yielded reports of an additional 24 cases of elder sexual abuse by caregivers.

Thus far, no formal studies of elder sexual abuse in institutional settings have been reported, although anecdotal case data is emerging. In a preliminary study underway in England, 30 cases of elder sexual abuse had been identified by June 1992. Five of these occurred in institutions, the remainder were in domestic settings (Holt, 1992).

Elder sexual abuse victims deserve our attention and protection. It is important that professionals serving elders learn about this problem, screen for sexual abuse when indicated, and assist victims in gaining protection from further abuse. One consequence of the recent identification of this problem is that most of those responsible for investigating cases of elder abuse have not received training specific to sexual abuse. Lack of training frequently results in failure to recognize, substantiate, and intervene in cases. Workers who have dealt with cases of elder sexual abuse report frustration with the lack of available literature and training. This article is offered to assist professionals in knowing when to suspect elder sexual abuse and to serve as a guide to interviewing and assisting sexually abused elders.

The guidelines are applicable to elder abuse investigations in both domestic and institutional settings. Many of the suggestions can also be applied to investigations of suspected sexual abuse among developmentally, cognitively, and physically impaired adults of varied ages.

SUSPICIONS OF POSSIBLE SEXUAL ABUSE

Sexual abuse of an elder should be considered as a possibility in two situations. The first is when an elder reports sexual victimization. The second is when symptoms commonly associated with sexual victimization are present. These symptoms are listed below. Many of these signs are also indicative of problems other than

abuse. The presence of one or more of these does not prove the existence of sexual abuse, but rather suggests the possibility. Professionals, paraprofessionals, and other individuals should report cases of suspected elder sexual abuse to the agency legally mandated to investigate cases of elder abuse.

Symptoms of Possible Elder Sexual Abuse

Genital or urinary irritation, injury, infection, or scarring
Presence of sexually transmitted disease
Intense fear reaction to an individual or to people in general
Nightmares, night terrors, sleep disturbance
Phobic behavior
Mistrust of others
Extreme upset when changed, bathed, or examined
Regressive behaviors
Aggressive behaviors
Disturbed peer interactions
Depression or blunted affect
Poor self-esteem
Self-destructive activity or suicidal ideation
Coded disclosure of sexual abuse

A "coded" disclosure is a hint, rather than a direct statement, of sexual victimization. Victims of sexual violence often wish to disclose their experience to seek help, but fear may prevent them from directly disclosing. They may instead "test the waters" by hinting at their victimization to see how others react. These hints, particularly if accompanied by any of the other indicators listed above, should cause suspicion of elder sexual abuse.

A case[1] presented to the author for clinical consultation illustrates the "coded disclosure." For example, Mrs. B., a 69-year-old partially paralyzed nursing home resident, consistently expressed dislike toward one of the aides, Martha. When this aide was assigned to her unit, she often asked if the other aide could be the one to bathe her. When the staff social worker asked the reasons for this, Mrs. B. stated that she did not like the way Martha washed her, but did not elaborate. Several months later another resident, Mrs. S.,

tearfully confided to her daughter that Martha regularly inserted her fingers and other objects into Mrs. S.'s vagina and rectum during bathing. The daughter, in turn, complained to the administration, which prompted an investigation. In retrospect, Mrs. B.'s statements were recognized as coded disclosures of sexual abuse. Mrs. B. was interviewed and revealed that Martha had sexually assaulted her during bathing in the same manner as described by Mrs. S.

Mrs. B.'s coded disclosure (repeated statements that she did not like Martha and did not wish to be bathed by this woman) were accompanied by the additional indicators of mistrust and fear (toward Martha), and upset when bathed. Unfortunately, coded disclosures are easy to overlook or misinterpret as suggestive of problems other than sexual abuse. Individuals serving elders need to be aware of coded disclosure. When recognized, these statements should be carefully explored by a trained interviewer in an attempt to determine if sexual or other types of maltreatment have occurred.

WHAT TO LOOK FOR WHEN INTERVIEWING

Sexual abuse occurs when an individual is forced, tricked, threatened, or otherwise coerced into sexual contact of any type against his or her will. A broad range of activities constitutes sexually abusive behavior. On one end of the spectrum, the abuse is covert. No sexual contact occurs, but the perpetrator engages in offensive verbal and/or nonverbal behavior of a sexual nature.

A second case referred to the author for clinical consultation illustrates the nature of covert sexual abuse. Seventy-two-year-old Mrs. J. resided with her daughter and son-in-law. While her daughter was absent from the home, her son-in-law frequently discussed his sexual relationships in explicit detail in the presence of Mrs. J. This included discussion of the sexual activities in which he engaged with his wife, as well as specific details of his sexual exploits with other women. Mrs. J. found this behavior offensive and threatening. When she asked him to stop, he laughed and continued his discussions. Mrs. J. was afraid to complain to her daughter, and thus endured the behavior for many months. She feared she would be

asked to leave the home if she was perceived as "causing trouble." Mrs. J. did discuss her son-in-law's behavior with her daughter when he began masturbating in her presence while discussing his sexual activities. In this case, disclosure was made when the abuse shifted from covert to overt.

Overt sexual abuse includes a pre-touching phase of exhibitionism and voyeurism and/or displaying pornography to an unwilling viewer. It further consists of physically intrusive acts such as sexualized kissing, molestation, oral/genital contact, digital penetration (insertion of fingers) of vagina or rectum, and vaginal and anal rape with penis or objects. Overt abuse also includes using the victim to produce pornography or allowing others sexual access to the victim.

While the vast majority of identified sexual offenders have been male, females have also been identified as perpetrators (Groth, 1979; Faller, 1987; Finkelhor & Russell, 1984; Finkelhor & Williams, 1988; Mathews et al., 1989; Ramsey-Klawsnik, 1990). It is important that professionals serving elders recognize this and consider allegations of suspected female offences as seriously as those allegations involving male offenders. Similarly, professionals need to be concerned about male as well as female victims. Male sexual abuse victims have been underserved in the past (Finkelhor, 1984; Lew, 1990; Pescosolido, 1989; Porter, 1986).

Investigators should be aware that in many documented cases of sexual abuse multiple, as opposed to single, perpetrators have been identified (Groth, 1979; Faller, 1987; Finkelhor & Williams, 1988). Reports of sexual victimization should not be seen as lacking credibility because they contain allegations of multiple perpetrators.

It is not unusual for individuals sexually assaulted by family members to have ambivalent feelings toward their offenders. The presence of mixed feelings is quite common. The fact that an elder who alleges sexual victimization displays love, loyalty, and attachment to the offender should not be considered evidence that the allegation is fictitious. It is not uncommon for victims to recant their allegations following disclosure. This can occur for a variety of reasons, including love and loyalty toward the offender.

GUIDELINES FOR INTERVIEWING SUSPECTED VICTIMS

The following guidelines are offered to elder protective service workers, medical personnel, law enforcement officers, and others who may be responsible for interviewing elders for possible sexual abuse.

Who Should Interview?

An interview to screen for sexual abuse should ideally be conducted by a trained and experienced individual. Interviewing victims is easier and more effective when the interviewer is knowledgeable regarding elder maltreatment and sexual victimization. It is also far more comfortable for the victim to have a trained and experienced interviewer. In some cases, the sex of the interviewer is significant. Some victims feel more at ease talking to a member of their own sex about this problem. Others are able to discuss the abuse with interviewers of the opposite sex, provided they are skilled and compassionate. An interviewer of the opposite sex may perceive victim discomfort and embarrassment, which might be alleviated by providing a same sex interviewer. In this event, the elder should be offered the opportunity to discuss the abuse with a same sex interviewer.

Location of Interviews

Interview the suspected victim privately, unless that person states a desire to have a "trusted other" present. Outnumbering a sexual abuse victim with multiple interviewers is intimidating to the victim and likely to make disclosure difficult or even impossible.

The ideal site for a sexual abuse interview is an office in which privacy and lack of distractions are assured. It is particularly important to assure privacy from the suspected offender. Many abused elders suffer from physical impairments that make travel to an office impractical. In these situations, it may be necessary to conduct the interview in the elder's home or institutional setting. If the sexual assault occurred at that location, the victim may not feel safe

there. When interviewing at the site of the suspected abuse, take steps to insure the victim's sense of safety, or disclosure will not occur.

For example, Mrs. N. is bedridden and resides with her alcoholic husband. She suffered recurrent, unexplained vaginal bleeding and frequent bruising about the wrists and ankles. Home health aides noticed that Mrs. N. displayed fear of her husband, particularly when he was drinking. When questioned by the aides about her vaginal bleeding, Mrs. N. became highly anxious and mumbled inaudibly. The home health aide agency reported these observations and concerns of possible abuse to adult protective services. It was not appropriate for the protective service investigator to interview Mrs. N. in her husband's presence. Her bedridden status made interviewing in the protective service office impractical. Protective service staff decided to visit the home on Thursday afternoon when Mr. N. did the weekly grocery shopping. A female worker conducted a sexual abuse screening interview, while her male coworker waited in another room to intervene with Mr. N. in the event he returned home early. During the interview, Mrs. N. confided that several times weekly her husband tied her wrists and ankles to her hospital bed and vaginally raped her.

Conducting the Interview

Rapport-Building. It is necessary to introduce oneself and develop a rapport with the client prior to asking questions about possible victimization. It may be helpful to arrange for a concerned relative or a trusted service provider to introduce the interviewer to the elder. During rapport-building the investigator and elder become acquainted, and the interviewer communicates interest in and respect for the elder. Respect can be conveyed in a variety of ways. Calling the person by her last name (Mrs. Jones) until she invites you to call her by her first name (Mary) is one example.

Allow the elder to have as much control over the interview as possible. For example, when making a home visit to an ambulatory elder, ask where she would like you to sit. Control helps a victim to feel empowered and more able to discuss the abuse Refrain from taking notes during early portions of the interview. It is intimidating

to victims and interferes with building and maintaining rapport. If sexual abuse is disclosed, the interviewer can then explain the need for precise notes. The client can be asked to clarify important points and notes can be taken. If the victim is upset by note-writing, do not take notes during the interview, but rather immediately following the interview while memory is fresh.

Screening for Sexual Abuse. In screening for possible sexual abuse, questioning must be accomplished in a way that maintains rapport and preserves the dignity of the elder. Proceed slowly and carefully, at the elder's pace. Use speech and language that are easily comprehended and comfortable for the elder. Ask only one question at a time. Tell the elder that he is free to refuse to answer any or all questions. Phrase questions in a non-leading, non-suggestive manner that will not compromise the credibility of the interview should sexual abuse be disclosed. It is appropriate and necessary to ask direct questions, but these are different from suggestive questions. A suggestive question is one which implies its own answer, for example, "Someone has sexually assaulted you, isn't that true?" Inappropriate questioning may cause disclosures to be dismissed and result in lack of protection for the victim.

Initially, ask open-ended questions designed to screen for sexual abuse. Should open-ended questions fail to lead to disclosure, ask more focused questions. The precise nature of the questions will be related to the information that led to the suspicions. If a previous disclosure has been made, begin with that information.

In a previously cited case example, Mrs. S. disclosed to her daughter that Martha, a nurse's aide, had raped her. Following a 20-minute period of rapport-building the protective service interviewer explained her job as talking to older people to see if they are safe. She then explored suspected sexual abuse by stating, "I understand you shared some very important information with your daughter. She told the nursing home administrator, and that's why I came to visit with you. Can you tell me about it?" When this general inquiry failed to lead to a disclosure, the interviewer probed further, "I have spoken with your daughter, and she told me you have some important concerns about Martha. I'd like to know about those concerns so that something can be done about them."

When screening for sexual abuse in the absence of a previous disclosure, the interviewer might ask about presenting symptoms suggestive of sexual abuse. For example, "Mrs. N., the home health aides who come to help you have been concerned about the marks on your wrists and ankles and about the unexplained bleeding. Can you tell me what's been causing these problems?"

Another approach to focused sexual abuse interviewing is to discuss one's role, particularly that of protective service investigator. For example, "I work for the Department of Elder Affairs. My job is to talk to older people to find out if they are okay. I talk to lots of older people who have been hurt, sometimes even by people they love. Some seniors are hurt by neglect, when someone they depend upon fails to give them the things they need, like food or medicine. Sometimes seniors are hurt by physical abuse when they are hit, kicked, or hurt in some other physical way. Some are hurt when others take their money or property without permission. Some seniors are hurt by sexual abuse, when another person forces them into a sexual act against their wishes. When I find out that any of these things are happening, I work very hard to make the hurting stop. Has anything like this ever happened to you?"

If the elder denies sexual assault, but clinical evidence suggests the contrary, embarrassment or fear may be prohibiting disclosure. Provide information about elder abuse, particularly elder sexual abuse. Explain that sometimes people cannot talk about things like this when they are first asked because it is very upsetting. Let her know that you can help if she is being hurt. Tell her that she does not have to tolerate any kind of assault. Explain that you have concerns about her safety and plan to return again in several days to provide another opportunity to talk.

If an elder discloses that he or she has been sexually victimized, remain calm and ask the victim to tell you more about it. Assure your client that she is an important and valuable person who deserves to be safe and that you will work to ensure safety from further sexual assault.

Disclosures such as those presented in the case examples are likely to elicit strong emotional reactions within interviewers. Refrain from sharing these emotional reactions with victims. Interviewers may need to process these reactions with a supervisor,

colleague, or other appropriate person. Do not express judgment, anger, or other emotion toward the offender. Although the interviewer may feel disgust and rage toward the offender, the client may love the offender and not wish that person any harm or retribution. Explore the victim's feelings about the abuse and the offender. When appropriate, validate the victim's feelings.

Ask clarifying questions following an elder's disclosure of sexual abuse. It is important to ask when and where the abuse happened and the frequency of occurrence. It is also important to determine the specific abuse activities. Often, multiple forms of maltreatment occur. Ask sexually abused elders if the perpetrator engaged in any other offensive behavior. This often leads to additional disclosures of accompanying physical abuse, neglect, or emotional abuse. Ask if anyone else, in addition to the identified perpetrator, has committed similar acts. If the victim indicates an unwillingness to continue the discussion, respect those limits. One can return to finish an incomplete interview at another time, should the victim be unable to provide all the necessary data at one sitting.

Interviewing Elders with Speech and Language Limitations. Abused elders unable to verbally communicate due to speech and language impairments can often convey their experience nonverbally. A variety of nonverbal means can be employed in the interview. Prior to the meeting with the suspected victim, the interviewer should inquire about the elder's usual method of communication and conduct the interview using that method. For example, the interviewer may learn that the elder is an aphasic stroke victim who communicates effectively through nodding.

Communication with people who are able to use their hands or fingers for pointing can be greatly enhanced through the use of large cards reading "YES," "NO," and "PASS." Questions can be posed to allow yes/no answers. "Pass" provides a way for subjects to avoid answering questions they are unprepared to handle. Elders unable to read can use cards indicating a "+" for a positive response, and a "−" for a negative response. Pass can be indicated by a blank card.

Anatomical drawings (Forensic Mental Health Associates, 1984) can be used to elicit details of the victimization when a positive response indicates the elder has been sexually abused. This tool

consists of a set of 32 line drawings of front and back views of males and females at four stages of development (pre-school, grammar school, teenage, and adult). Although the set does not contain elders, seniors can point to or mark the adult drawings to demonstrate what part of their bodies have been violated. The drawings also enable nonverbal victims to indicate the parts of the body the offender used in the assault.

Anatomically detailed dolls have been used extensively to assist child victims in demonstrating their sexual abuse (Boat & Everson, 1986; Faller, 1990; MacFarlane & Waterman, 1986). Many of the doll manufacturers produce male and female elder dolls to accompany the adult, child, and infant doll sets. The author has found anatomical dolls to be an effective means of communicating with adult sexual abuse victims who are unable to speak or who have limited verbal ability. Victims can point to parts of the doll to indicate how their bodies were assaulted. Victims can also point to areas of a doll representing the offender to indicate what body parts were used to abuse. In addition, dolls representing victim and offender can be manipulated to demonstrate the abuse activities.

Nonverbal means of communication such as drawings and dolls can also be utilized with elders who can speak but are too uncomfortable to use words to describe their assault(s).

INTERVENTION

Following case identification, a number of steps must be taken to insure the safety and well-being of the elder sexual abuse victim. Tell the sexually abused elder that she is not alone in her victimization. Explain that she is not at fault. Provide the client an opportunity to ask questions. Many victims, even those who are mentally competent and capable of wise decision-making, enter a state of crisis following sexual assault. It is important that intervening professionals explain options and give information about victims' rights and steps necessary for protection. All sexual abuse victims, including elders, should be encouraged and supported in making as many decisions as possible themselves.

The following tasks should be accomplished:

- Provide emotional support to the victim. Sexual assault is humiliating, emotionally traumatic, and often physically painful and injurious. Discussing the abuse can cause painful emotions and memories to surface. Victims may require crisis intervention, rape counseling, or other forms of mental health intervention. If the interviewer is not equipped to deliver counseling services, a referral should be made to an appropriate agency or individual. It is very important that sex abuse victims not be left alone to deal with their emotional pain and trauma.
- File all appropriate reports with elder or adult protective services as legally required in your state. In some states, protective service workers and other professionals must also notify law enforcement officials.
- If necessary, seek legal intervention such as a restraining order to assure the protection of the victim.
- Arrange for medical services for the victim, including appropriate procedures after a sexual assault. Ask the elder if she would like a trusted person to accompany her through the examination.
- The victim should be protected from all unsupervised contact with the offender. If the victim is left alone with the offender, repeated abuse is likely. Even if the offender admits the problem and promises to refrain from further assault, it is critical to prohibit unsupervised access to the victim. Sexually abusive individuals should not have any power over the victim, should not be allowed to make decisions for the elder, and should not be responsible for any caregiving. The elder may love the perpetrator and wish to have visitation, particularly if he is a family member. If so, visits should be arranged. However, visits must be carefully supervised to prevent repeated assault. Plans for protecting the elder from the abusive caregiver should be made in a manner that least disturbs the victim. For example, it is more appropriate to have the offender leave the home, rather than the victim.

A very difficult and frustrating situation occurs when an elder discloses sexual victimization but refuses protective services to

prevent further abuse. If the elder is competent to make independent decisions, these decisions must be respected. In situations in which the elder is not competent, normal protective service procedure should be implemented to insure the individual's safety.

NOTE

1. Identifying information regarding this and the subsequent case examples has been deleted and/or altered to protect the confidentiality of the victims.

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