U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

REPORT FROM THE SECRETARY'S TASK FORCE ON ELDER ABUSE

February 1992

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This paper was by HHS's Office of Family, Community and Long-Term Care Policy (now DALTCP). For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Floyd Brown.

REPORT FROM THE SECRETARY'S TASK FORCE ON ELDER ABUSE

Secretary's Task Force on Elder Abuse

February 1992

Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services.

TABLE OF CONTENTS

RECOMMENDED STRATEGY 1
ACTIVITY 1. Implement a Research and Data Base Strategy 2
ACTIVITY 2. Develop State and Local Capacity to Address Elder Abuse and Neglect Issues 4
ACTIVITY 3. Promote Targeted Public Education Activities 5

BACKGROUND PAPER ON ELDER ABUSE 8
Purpose 8
Background 8
Definition of Elder Abuse 9
Incidence of Elder Abuse 10
Causes of Abuse 13
Current Policies and Programs 15
Limitations of Current Policies and Programs 19

RECOMMENDED STRATEGY

The task force proposes a three-part strategy for the Secretary's consideration. The strategy is a comprehensive departmental action plan that addresses the prevention, identification and treatment of elder abuse and neglect in home and community-based settings and in nursing homes.

Despite increased media coverage and state and community concern, it is premature to try to develop a systematic legislative response to the problem of elder abuse and neglect because there is insufficient information and understanding about the nature and extent of the problem, how it is changing over time and its causes.

Nevertheless, the interagency task force recognizes that there is, indeed, a problem. Therefore, it is incumbent upon the Department to determine the barriers faced by practitioners attempting to cope with elder abuse and neglect and identify and disseminate strategies to overcome those barriers.

1. **Develop and fund a national research and data collection strategy.**

    - The National Institute on Aging (NIA) with the support of the Administration on Aging (AoA) and the Health Care Financing Administration (HCFA) will initiate activities to set research priorities and address methodological issues related to the development of both a national data collection strategy and a research strategy The purpose of these activities is to develop a comprehensive understanding of the problem.

2. **Develop and fund a hands on technical assistance and training program.**

    - Each agency will establish a collaborative mechanism to determine the need for information, technical assistance and training in areas such as the identification and reporting of abuse and neglect, the investigation and resolution of specific incidents and the prevention and treatment of elder abuse and neglect. The mechanisms will link various agencies of the Department with elder abuse and neglect responsibility to: representatives of state and local government, the legal system, including law enforcement officials; provider and consumer groups; and practitioners who are knowledgeable about areas related to elder abuse and neglect.

    - Mechanisms such as workshops, regional conferences, agency grant programs and the AoA, HCFA and Social Security Administration (SSA) communications networks will be used to identify, develop and disseminate "best practices" to the elder abuse and neglect network.

3. **Develop and promote targeted public education activities.**

- These activities will include speeches and testimony given by Departmental policy-level officials, and development of the existing Departmental communications networks to disseminate information relevant to elder abuse and neglect issues. The activities will be directed to professional and volunteer groups that administer elder abuse and neglect programs.

ACTIVITY 1: Implement a Research and Data Base Strategy

Discussion

The Task Force recommends that the Department develop a comprehensive research strategy on the prevalence and causes of elder abuse and neglect which includes (1) the creation of a national data collection strategy on elder abuse and neglect and (2) targeted studies that will lead to a fuller understanding of the causes of elder abuse and neglect and effective methods for identification, treatment and prevention. This includes research that will pro-mote, for example, the identification of precursors of abusive situations and in-depth studies of specific situations and conditions related to elder abuse and neglect.

Both state and federal policy on elder abuse and neglect issues will benefit from a deeper understanding of its causes. A number of state-specific data systems exist but they are based on disparate definitions of key terms and geared to individual state needs. There is no uniform national system that allows us to address such basic issues as the extent of the elder abuse and neglect problem, who is involved, the nature and causes of abuse and whether the magnitude of the problem is changing over time.

Proposed Action Steps

A. Convene a Cross-section of Federal, State and Local Officials with Elder Abuse and Neglect Responsibility and Leading Researchers to:

1. Review and critique the literature on elder abuse and neglect.

2. Formulate guiding hypotheses for collecting information based on the best available data.

3. Determine new data needs. For example, what kind of information is needed to understand and monitor the issue over the next five years? Do we need better information about abuse in all settings or only some?

4. Identify research priorities and key policy questions.

B. Convene Survey Experts to:

1. Define the full range of behaviors and situations which should be included in studies of elder abuse and neglect.

2. Recommend data collection instruments and procedures that will capture the full range of elder abuse and neglect situations.

3. Identify data collection strategies, sampling frames, and the cost of alternative approaches for measuring the prevalence of elder abuse and neglect. For example, should we design a new survey, add on to an existing survey, mine state and local data? What are the quality and limitations of existing data?

4. Suggest appropriate scientific approaches for clinical trials and intervention research for elder abuse prevention and treatment.

Lead Agencies

The National Institute on Aging, in close coordination with the Administration on Aging, the Health Care Financing Administration and the DHHS Task Force on Aging Research, will be the lead agency for the on-going coordination of this strategy.

Expected Outcomes

A. Conduct workshops to determine data needs and identify research priorities.

B. Prepare a report that identifies the major data needs and research priorities related to elder abuse and neglect issues. The report will be used to provide survey experts with guidance they need to develop data collection procedures.

C. Conduct workshops to develop data collection options.

D. Prepare a report that identifies and discusses the data collection options available to the Department.

E. Prepare periodic syntheses of data to build an understanding of elder abuse and neglect.

ACTIVITY 2: Develop State and Local Capacity to Address Elder Abuse and Neglect Issues

Discussion

Although data must be generated over the long run that will allow us to address elder abuse and neglect issues comprehensively, more immediate efforts are needed to assist states and localities to respond to the problems they face on a day-to-day basis. Each Department agency that serves constituencies vulnerable to elder abuse and neglect will develop collaborative networks linking them to representatives of state and local government, provider and consumer groups, and practitioners knowledgeable about elder abuse and neglect issues. Such a mechanism will allow state and community participants to articulate their needs and explore how we can best respond to those needs.

Proposed Action Steps

A. Identify and Prioritize Information, Training and Technical Assistance Needs.

1. Participating HHS agencies will use the AoA Eldercare Institute on Elder Abuse and State Ombudsman Services to assist in identifying the information, training and technical assistance needs of the elder abuse and neglect network. The participating agencies will identify the primary methods to collect the data.

2. Based on this information, each agency will develop a plan that identifies and sets priorities for the topics of interest to the network. This information will be used to identify topics for the workshops and seminars cited below, set grant announcements priorities, and develop training materials.

B. Convene Workshops, Seminars, and Regional and State Conferences to:

1. Share issues and problems around specified topics, identify examples of best practices, identify information and technical assistance needs, and locate innovative resources that can be disseminated to states and communities in response to their needs.

2. Identify methods for developing/disseminating information including use of state Offices on Aging, the elder abuse and ombudsman clearinghouses, SSA field offices, the Area Agency on Aging network, HCFA beneficiary counseling, eldercare coalitions, etc.

C. Incorporate Information and Technical Assistance Needs into Agency Planning Process.

Lead Agencies

AoA, in conjunction with NIA, HCFA, the Health Resources and Services Administration (HRSA), the Social Security Administration (SSA), and the Indian Health Service (IHS) will be responsible for coordinating capacity building activities which focus on elder abuse and neglect in family settings and in the formal home and community-based services system.

HCFA, in conjunction with AoA and HRSA will coordinate capacity building activities addressing elder abuse and neglect in nursing homes.

Each agency will develop plans for incorporating information and technical assistance needs into its discretionary program announcements.

Expected Outcomes

A. Identify training, information and technical assistance needs of elder abuse and neglect network.

B. Convene workshops/seminars or other types of meetings identified above.

C. Develop plans to incorporate technical assistance and training needs into each agency's research agenda.

ACTIVITY 3: PROMOTE TARGETED PUBLIC EDUCATION ACTIVITIES

Discussion

Public education activities need to be targeted to support state and community efforts to deal with elder abuse and neglect. In the short run, we believe the primary audience for public education activities should be professional and volunteer groups who administer elder abuse and neglect programs rather than the public at large. We do not think it is useful to transmit general messages of concern to the public without a concomitant improvement in our understanding of the prevalence and causes of elder abuse and neglect. This is particularly true in the area of domestic abuse and neglect where knowledge is extremely limited and the systems for intervention and resolution are not generally well developed.

Proposed Action Steps

A. Speeches, Testimony, etc. by Policy-level Officials

This activity will consist of speeches, testimony, etc. made by policy-level officials such as the Commissioner of AoA, the Director of NIA, the Administrator of HCFA and the Commissioner of SSA. These officials often address professional groups that

comprise the aging and health networks and have a direct interest in the Department's elder abuse and neglect activities.

The purpose of this strategy is to educate various professional groups about: the magnitude, nature and causes of abuse and neglect; best practices; and other issues of concern, for example, how to limit the use of restraints in nursing homes, and how to improve the coordination of the various members of the elder abuse and neglect network at the state and community level. The strategy will also support a collaborative process with professionals in the field to identify and resolve problems.

B. Federal Interagency Task Force on Elder Abuse

There are a number of Federal agencies with a direct interest in elder abuse. They include the Departments of Justice, Housing and Urban Development and the Department of Veterans Affairs. Many victims of'elder abuse receive services from one or more of these Departments. The Secretary will formally invite his counterparts to participate on an Interagency Task Force on Elder Abuse.

The purpose of this strategy will be to encourage coordination and cooperation across agency and programmatic lines within agencies. The strategy win also serve to educate the various government agencies about programs that address elder abuse.

C. HHS Communication Networks

The Department has an extensive communications network that links providers, state and local officials and the elderly with HHS programs. These communication links include SSA field offices, the State and Area Agency network, the HHS regional offices, and the HCFA beneficiary counseling mechanisms among others. These networks can be used as targets of opportunity by each participating agency to disseminate information on specific elder abuse and neglect issues.

For example: HCFA could include in its proposed guide to the selection of a nursing home information to help consumers identify various indices of potential institutional abuse. SSA, in collaboration with the State and Area Agencies on Aging and HCFA, could mail out an information sheet to its field office personnel listing the local numbers and responsibilities of various agencies involved with elder abuse and neglect.

Expected Outcomes

A. This activity will inform a targeted audience about what is known about elder abuse and neglect and what HHS is doing about the problem.

B. This activity will be implemented by making the Federal Interagency Task Force on Elder Abuse a sub-task force of the Federal Interagency Task Force on Aging that is chaired by Joyce Berry, the Commissioner on Aging. The strategy will

improve coordination and communication across agency lines especially in the content of research and grants announcements that deal with elder abuse. It will also move the activity beyond HHS and potentially broaden the resource base available to address elder abuse and neglect issues. It is hoped the result will be a systematic approach to addressing elder abuse and neglect issues and firm commitment of funds by the participating agencies.

C. These activities can be implemented quickly within the current framework of Departmental activities.

BACKGROUND PAPER ON ELDER ABUSE

PURPOSE

The purpose of this paper is to provide background information which summarizes various perspectives on the definitions, incidence and causes of abuse of elderly citizens in institutional and domestic settings. Also, this paper will describe the range of programs, both in HHS and in the states, that address elder abuse. Finally, the paper identifies issues that have been raised by practitioners, policymakers and others which should be considered by the members of the Task Force on Elder Abuse. Among the issues are:

- lack of reliable data and a consistent data collection system;
- lack of coordination among state, federal and local agencies involved in elder abuse;
- lack of resources to carry out existing mandates;
- lack of accurate public knowledge about elder abuse; and
- lack of a uniform definition of elder abuse.

The public remedies for preventing and treating abuse in private homes are likely to be quite different from the remedies for abuse in institutions. The fact that the public pays for most of the care provided in long term care facilities provides a strong incentive for sanctions against institutional abuse. The result has been extensive uniform standards that address abuse in institutions. Abuse that occurs in private homes is less subject to public review and has comparatively fewer standards to draw upon. This paper addresses both types of abuse.

BACKGROUND

Although elder abuse is not a new phenomenon, it has only recently been recognized as a growing social problem. The increasing numbers of older people in the population, the success of the child abuse movement in focusing interest on family violence, and research findings and Congressional hearings of the 1970s and 1980s have helped increase public awareness of elder abuse.

Elder abuse has long been a concern of various agencies within the Department of Health and Human Services (HHS). For example, the Administration on Aging (AoA) manages the state long term care ombudsman program which investigates complaints of abuse on behalf of nursing home residents. The Health Care Financing Administration (HCFA) surveys and certifies the safety of residents and the quality of care provided in nursing facilities funded by the Medicare and Medicaid programs. It also oversees implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Acts of 1987 and 1990. Other HHS components with some

involvement in elder abuse include: the Social Security Administration (SSA), with its "representative payee" program; the Administration for Children and Families (ACF), which certifies states' compliance with the Keys Amendment standards for board and care homes; and the National Institute on Aging (NIA) which sponsors research on elder abuse.

In April, 1990, at a meeting on nursing home issues, Secretary Sullivan (DHHS) asked the heads of agencies that deal with elder abuse to collaborate on the development of an intradepartment strategy to address elder abuse in both institutional and home environments. He stressed that the group should develop a strategy that combines public and private resources at all levels of government--national, state and local.

DEFINITION OF ELDER ABUSE

There is no universally accepted definition of the phrase "elder abuse". Many definitions of “elder abuse” have been developed by researchers, clinicians, policy analysts and legislators, but these definitions generally reflect a single and, often, limited focus. The result is enormous interstate variation in the definitions, laws and reporting requirements associated with elder abuse and neglect.

In 1985, the American Public Welfare Association (APWA) conducted a 50 State survey of state definitions of institutional elder abuse. Through a review of State statutes on abuse/protective services, APWA staff found that "abuse" usually refers to "any intentional act that results in physical or psychological injury to a resident in a long term care facility." They also determined that "neglect" refers to "a failure to provide for the care that is necessary to maintain the physical and mental health of the individual."

Domestic abuse has been defined differently over time by researchers, professionals and public policy makers. At the federal level, the 1987 Amendments to the Older Americans Act focused on three major types of abuse: physical abuse; neglect; and exploitation. State statutes, however, vary considerably in terms of scope, definitions of the types of elder abuse they cover, and other features.

Some researchers maintain that the lack of uniform definitions of elder abuse have made it difficult to draw firm conclusions from research findings, and inhibited the development of a national database on elder abuse. Since legislative and financing decisions are integrally intertwined with how issues are defined, it is not surprising that the response to the problem of "elder abuse" is uneven in terms of public awareness, funding and strategies to assist victims.

Although it may be impossible to completely resolve the definitional confusion, an examination of the literature reveals that there are some common threads among definitions, which may offer a starting point for consensus.

- First, all discussions of elder abuse recognize physical violence as abusive behavior.

- Second, most of the literature includes a category of psychological or emotional abuse.

- Third, exploitation involving property or finances is widely recognized as a form of abuse.

- Finally, neglect appears as a category of abuse in most of the literature.

The challenge, of course, is to define these common components of abuse in a way that is useful across research, public policy and service delivery settings.

INCIDENCE OF ELDER ABUSE

It is very difficult to accurately assess the national incidence of elder abuse due to a variety of factors including lack of a universal definition, inadequate reporting, lack of interagency coordination and lack of national data on the number of substantiated incidences of elder abuse. Nevertheless, a review of available sources shows that elder abuse is a significant problem for vulnerable elderly individuals in all types of settings.

A. Institutional Abuse

1. Abuse in Nursing Homes and Board and Care Homes

There is limited uniform national data on the incidence of abuse in long term care facilities, but, based on the findings of numerous researchers and policymakers, both psychological and physical abuse appear to occur with some frequency. A sense of the scope and nature of the problem can be gleaned from several sources, including academic research, state and federal program data and a recent study by the DHHS Office of the Inspector General (OIG).

Karl Pillerner of the University of New Hampshire is recognized for having conducted the broadest study to date involving interviews with direct care workers. He interviewed over 500 nurses and nurse aides regarding incidences of physical and psychological abuse they had witnessed or committed over the previous year. Physical abuse was defined as “an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person.” Similarly, psychological abuse was defined as "an act carried out with the intent, or perceived intent, of causing emotional pain to another person (e.g., threats or insults)." Among his most significant findings were:

- Eighty-one percent of respondents had ob-served one or more incidents of psychological abuse during the previous year. Forty percent of the respondents admitted committing such acts.

- Thirty-six percent of the respondents had observed at least one incident of physical abuse during the previous year.

"Abuse occurs frequently in nursing homes," was a key finding reported in "Resident Abuse in Nursing Homes," a study conducted in 1990 by the Office of the Inspector General. In conducting this inquiry, the OIG interviewed Ombudsmen, State Medicaid Fraud Control Unit staff, and coordinators for complaints in nursing homes in 35 States. Those interviewed cited physical and emotional neglect, and verbal or emotional abuse as the most prevalent manifestations of the problem. The OIG concluded that the problem of abuse in nursing homes warrants further federal and state action.

In a review of the formal complaints filed with state Ombudsmen, the Administration on Aging found that one half the complaints involved “resident's care” (subsuming physical, sexual and verbal abuse or neglect) or "resident's rights" (which includes abuse by other residents, theft of personal items and violations of privacy, confidentiality, and civil rights).

A recent study done by California's Ombudsman program, the largest in the country, found that of the nearly 30,000 complaints received statewide regarding skilled nursing facility residents, one half involved potentially abusive situations (these included among others, alleged physical or sexual abuse, alleged neglect, alleged violations of resident rights, alleged thefts and losses). This is especially significant since California's Ombudsman program receives approximately one-third of the total complaints submitted to Ombudsmen in the country.

Finally, HCFA collects data on the frequency of nursing homes found out of compliance with requirements that residents be free from mental and physical abuse. The HCFA data show that less than 2 percent of Medicare and Medicaid certified nursing homes were found out of compliance with the requirements. It should be noted that these are facility-based data that may not accurately capture individual incidences of abuse.

2. Abuse in Board and Care Homes

Data regarding abuse in board and care homes are less available, although what is known suggests that the problem is at least as widespread as in nursing homes. Among the reasons for the dearth of data are:

- Definitions of the term "board and care home" varied from state to state.

- Regulation of board and care homes is primarily a state responsibility, so there are neither national compliance requirements nor national data sources.

- There is a high level of interstate variation in licensure and enforcement programs.

Roughly two-thirds of board and care home residents are elderly and female, and, because of functional disabilities, must rely on others for their care and protection. In its recent report "Board and Care Homes in America: A National Tragedy," the House Select Committee on Aging concluded that board and care residents are frequently the victims of fraud, neglect and abuse. According to the report, of a total of 5,355 complaints of abuse in nursing homes and board and care homes reported by 24 states during 1987, 51 percent (2,724) of the complaints were in board and care homes.

The Ombudsman program is the only federal program authorized to investigate complaints in both types of settings. Yet, Ombudsmen contend funding levels limit the ability of most Ombudsmen to receive and investigate complaints in board and care settings. A cursory examination of data collected in states where Ombudsmen are active in board and care homes indicates that complaints of abuse and neglect occur at least as frequently as in nursing facilities.

B. Domestic Abuse

The absence of data also makes it difficult to develop reliable estimates on the prevalence and incidence of domestic elder abuse. While the prevalence of domestic elder abuse is not known, there have been recent national estimates developed on the number of reported incidences of elder abuse. These estimates are based on State data limited to "reports of domestic elder abuse" because there are no national data on the number of confirmed cases of elder abuse. For example, a report by the House Subcommittee on Health and Long Term Care estimates that about 1.5 million elderly Americans may be the victims of domestic elder abuse each year.

A study conducted by the National Aging Resource Center on Elder Abuse (NARCEA) shows the incidence of elder abuse is rising. NARCEA estimated that the number of domestic incidents increased from 1.6 millionin FY 1986 to 2 million in FY 1988. These estimates were derived by applying the rate of reported vs. unreported cases developed by Pillerner and Finkelhor (1 in 14). NARCEA!s survey of the states disclosed that in 1988 there were 140,000 reported cases of elder abuse. When this number is adjusted using Pillemer's rate of unreported cases, the incidence of elder abuse reaches the 2 million level. Nonetheless, many experts view these figures as conservative because of the gross under-reporting typically associated with domestic elder abuse.

J. Kosberg identified the following five reasons for under-reporting of this form of abuse:

- family secrecy;
- acts that occur out of sight within family dwellings;
- the elderly individual's reluctance to report abuse;
- professional lack of awareness of the problem; and
- failure of responsible persons to report.

The NARCEA study also produced estimates of the major perpetrators and types of abuse occurring in domestic settings. NARCEA concluded that the major perpetrators of domestic elder abuse were adult children (30%), spouses (15%), and other relatives (17.8%). The major types of domestic abuse were neglect (37%), physical abuse (26%), and financial/material exploitation (20%).

CAUSES OF ABUSE

To develop a multi-pronged approach to eliminate elder abuse, it will be vital to identify and address its causes. In this section we summarize research theories and findings on the reasons why people abuse the elderly.

A. Causes of Abuse in Institutions and Board and Care Homes

Many theories have been offered about the causes of abuse in institutions and board and care homes. Some point out that advances in technology have increased the ability to prolong life. The result has been a medical delivery system pushed beyond its capacity to care for increasing numbers of "heavy care" patients. Such patients have more debilitating diseases that may require not only a more skilled level of care but also more assistance with routine activities of daily living. Factors such as inadequate staff ratios and high, turnover rates make it difficult for nursing facility staff and board and care home operators to maintain the level of care required for these patients. Studies of board and care homes showed that operators sometimes overuse and misuse medications, and inadequately supervise the dispensing of medications. In extreme situations in both institutions and board and care homes, the challenge of caring for large numbers of "heavy care" patients has resulted in the inappropriate use of physical or chemical restraints.

Another frequently cited cause of institutional abuse is the over-use of poorly trained and poorly paid nurse aides and orderlies. They often endure poor working conditions and long hours that create stressful conditions and become potential breeding grounds for abusive behavior. Respondents to the Inspector General's report on nursing homes cited insufficient training in behavior skills to cope with confrontational situations and the lack of stress management skills as major staff deficiencies. A parallel situation in board and care homes is the lack of training available to home

operators. Because of increased acuity, more and more board and care residents have special needs. Often, operators are not able to provide the care needed.

Problems also exist with the nurses who staff nursing homes. Nursing homes usually pay much less than hospitals and provide fewer benefits. Some contend that this encourages high turnover rates for nurses who work in nursing homes with the result that nursing home nurses may be less experienced and have fewer qualifications than those in other health care settings.

Some cases prosecuted by the Medicaid Fraud Control Units show that drug and alcohol abuse by staff is a factor in the abuse of residents. Further, anecdotal information suggests that staff who are victims of domestic violence may in turn abuse residents.

Although there are many similarities in institutional abuse and abuse that occurs in board and care homes, there is one important difference. Board and care residents are often isolated and vulnerable without the protection offered by family, friends and the government regulatory apparatus. Abusive situations often occur out of the public view and as a result are more likely to be unreported. This environment makes it more difficult to develop solutions to the problem.

B. Causes of Domestic Abuse

As with many social problems as complex as domestic elder abuse, the causes cannot be easily determined. Pillerner identified five factors associated with increased risk of elder abuse. They include: (a) psychopathology on the part of the abuser, (b) transgenerational violence, (c) dependency, (d) stress, and (e) social isolation. An examination of these factors shows that they may be applicable in all settings where abuse occurs--the vulnerable elderly may be equally dependent in community or institutional environments and caretakers can be subject to stress or prone to violent behavior in either setting.

James Callahan (1988) points out that in early studies researchers agreed that victims of 'domestic abuse were very old, functionally impaired, and abused by relatives. Upon closer examination, Callahan found that functional impairment was not a significant contributing factor to incidents of elder abuse. Pillemer (1985) found that many cases of elder abuse occurred in situations where the caretaker was financially dependent on the older person.

If older persons are vulnerable because of the dependency of another family member, Callahan suggests that there should be further research into social policies that affect families. Along the same lines, Kosberg speculates that it may be unwise to consider families as an unchallenged source of care; instead, he believes each individual family should be assessed to determine whether it is the most appropriate and safest caretaker. Brackman and Adelman (1988) advise that each case of elder

abuse should be examined to identify single and overlapping causes. Examination of the risk factors assists in determining the intervention methodology.

Current Policies and Programs

A. DHHS Role

In this section we will briefly summarize the elder abuse policies and programs of key components of the DHHS.

1. Administration on Aging

AoA administers the Older Americans Act which requires State Units on Aging to establish and operate an Office of the State Long Term Care Ombudsman. The ombudsmen, who act as advocates for residents in long term care facilities, must regularly submit data on complaints and conditions in long term care facilities to AoA. Although the ombudsman program provides a mechanism to investigate and mediate complaints of residents of long term care facilities, it cannot enforce laws or initiate sanctions against the facilities. In addition, the program does not mandate that cases of abuse be reported. Instead, it relies on voluntary complaints made on behalf of residents.

In addition, under its discretionary program authority, AoA funds selected research, training and demonstration projects on elder abuse and supports two (2) National Aging Resource Centers with important roles related to elder abuse.

a. The National Aging Resource Center on Elder Abuse is a joint undertaking of the American Public Welfare Association, the National Association of State Units on Aging and the University of Delaware. It provides data and expertise on elder abuse, operates the Clearinghouse on Elder Abuse and Neglect of the Elderly, publishes a newsletter and conducts special studies on elder abuse.

b. The National Center for State Long Term Care Ombudsman Resources is run by the National Association of State Units on Aging in collaboration with the National Citizens' Coalition for Nursing Home Reform. The Center provides training, technical assistance and information on the State Long Term Care Ombudsman Program. It also provides assessments, analyses, and advice on elder abuse issues in nursing homes and other institutional settings.

In FY 1991, 3 million dollars was appropriated in Title III of the Older Americans Act for an elder abuse prevention program. An additional 2.5 million dollars was appropriated for the long-term care ombudsman program. A portion of this money was to be made available to the state long-term care ombudsman to address complaints in long-term care facilities, including board and care homes.

2. *Health Care Financing Administration*

HCFA is responsible for administering the survey and certification process for nursing homes and other long term care facilities funded under the Medicaid and Medicare programs. Thus, HCFA influences the quality of care in nursing homes because it sets the minimum standards for care for all certified facilities. It also provides the protocols for state licensure and certification agencies to use for monitoring and enforcing compliance with Federal and State standards.

HCFA also is responsible for issuing regulations to implement the nursing home reform provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987. Besides establishing requirements for nurse aide competency and resident assessment, OBRA includes many other provisions directly related to the abuse and neglect of residents. For example, it includes provisions about the resident's right to be free from physical or mental abuse and creates a process for the receipt and review of alleged cases of abuse. It also requires the immediate reporting of suspected cases of abuse and the results of all subsequent investigations. It is anticipated that by establishing requirements and enforcement processes that focus on patient outcomes, OBRA 1987 will lead to improved quality of care in nursing homes.

HCFA will also have responsibility for developing and implementing regulations for OBRA 1990 which contains an optional Medicaid home and community care benefit for the elderly that became effective on July 1, 1991. The measure establishes minimum requirements for residents' care, sets standards for surveys of community settings in which care is provided, and requires the investigation of allegations of individual neglect and abuse and misappropriation of individual property.

3. *Social Security Administration*

In its function as payor of Social Security and Supplemental Security Income (SSI), SSA permits beneficiaries who cannot manage their benefits to have other persons act as their "representative payee." This includes adult beneficiaries who are unable to manage their benefits because of a mental or physical impairment, and SSI beneficiaries who are disabled by drug abuse or alcoholism. SSA administers the appointment of the payees, and conducts some monitoring of their performance. Many beneficiaries in residential facilities, particularly board and care homes, have representative payees (usually a relative) who provide them some level of care.

In 1989, at SSA’s request, the Inspector General's Office conducted an examination of representative payees in the Social Security program. The OIG found that although there is anecdotal evidence of problems in the representative payee program, the problems are not widespread and most beneficiaries are well served. The OIG also concluded that SSA could help alleviate existing problems by strengthening its role in screening potential representative payees and monitoring their performance. Based on this finding, SSA has included in the Secretary's FY 1991 Program Directions an objective to improve the representative payee system. Although SSA does not have

a current policy on elder abuse by representative payees, it will explore ways in which it can take a more active role in preventing the situations that contribute to the abuse of its beneficiaries. SSA will attempt to improve data collection on the system, expand payee outreach and resource development, and improve the monitoring of payees.

4. The Administration for Children and Families[*]

In 1976 the Congress passed the Keys Amendment (Section 1616(e) of the Social Security Act) in response to concerns about the living conditions of board and care residents. The Keys Amendment requires States to set and enforce standards for facilities in which substantial numbers of SSI recipients reside. Each year States certify to the Administration for Children and Families that they have standards in place for these facilities.

The only sanction for a facility that does not meet these standards is a reduction in the resident's SSI payment, which directly penalizes the resident rather than the facility. In addition the circumstances under which sanctions may be applied are not clear. Historically, the Department has not applied sanctions under the Keys Amendment.

5. National Institute on Aging

NIA supports several research projects that directly address elder abuse. These include a population-based study of abuse prevalence and one clinical investigation to develop alternatives to restraints in institutional care. The NIA research mission spans both institutional and domestic abuse. Less directly, the NIA supports a broader portfolio of research on elder care that is relevant to abuse issues including studies of the burden of care, board and care homes, characteristics of demented elders, and predictors of institutional placement.

6. The Indian Health Service

The Indian Health Service (IHS) is responsible for providing health care to all eligible American Indians and Alaskan Natives residing on reservations and historical Indian lands. The role of IHS in elder abuse is to provide primary, secondary and tertiary acute care, and preventive, rehabilitative and environmental health services. Information and referral services are provided when direct care is not available.

7. Health Resources and Services Administration

Two units of HRSA provide services and support that relate to elder abuse.

The Bureau of Health Professions funds grants for Geriatric Education Centers, Fellowships in Geriatric Medicine and Dentistry and a variety of geriatric nursing

---

[*] *Previously administered by the Office of Human Development Services*

projects. Many of these projects provide training for faculty, students and practicing health professionals in issues of elder abuse.

The Bureau of Health Care Delivery and Assistance provides and supports primary health care to a wide variety of people. Care is provided and opportunities are available for addressing elder abuse through the Community and Migrant Health Centers and the National Health Service Corps.

B. State Role

1. State Units on Aging

In all states, the State Unit on Aging (SUA) operates the Office of the State Long Term Care Ombudsman. The SUA requires that the ombudsman prepare an annual report containing data and findings regarding the nature of complaints received. The ombudsman must also provide policy, regulatory and legislative recommendations to, address those problems. Further, the ombudsman must provide training to Office staff and coordinate ombudsman services with other protective services.

2. Adult Protective Service Agencies

State Adult Protective Service (APS) agencies traditionally provide a range of services to vulnerable adults. These services are available to persons over 18 who are unable to provide for their needs and have no responsible caregivers. The APWA found in a recent survey that the APS agencies are the principal agencies responsible for the investigation and follow-up of domestic elder abuse cases and are also the primary agencies responsible for investigating institutional abuse cases.

3. Licensure and Certification Agencies

State Departments of Health and Welfare are typically the agencies that license or certify nursing homes and board and care facilities. All states must carry out survey and certification activities required by OBRA 1987. These activities may be done by a single agency or by several state agencies.

4. Medicaid Fraud Control Units

Medicaid Fraud Control Units exist in 38 states to investigate and prosecute provider fraud and patient abuse and neglect in health care facilities receiving payments under the state Medicaid plan. The units include attorneys, auditors, and investigators operating as a unit of the Office of the State Attorney General. Besides the unit's responsibility to investigate and prosecute Medicaid provider fraud, they have an equal responsibility to investigate and prosecute patient abuse or neglect in all health care facilities that receive Medicaid funds.

LIMITATIONS OF CURRENT POLICIES AND PROGRAMS

In this section we discuss five perceived problems related to addressing and eliminating elder abuse. The Task Force may have additional concerns to add to this list.

1. There is Insufficient Research and Statistical Data on Elder Abuse

Data collection and rigorous research on elder abuse are still in the beginning stages in most states. Consequently, there is a lack of data regarding confirmed incidences of elder abuse. Problems in gathering national data on elder abuse include the lack of uniform definitions; variation among states in the characteristics of persons covered by elder abuse laws; variations among states in the types of elder abuse covered in their reporting requirements; and inability of state data systems to desegregate data by common data elements.

Most of the current research on elder abuse is descriptive. While useful in shedding some light on the scope of the problem, it does not replace the need for analytic studies. According to Pillerner (1989), random sample population surveys and rigorous case-control design are sorely needed. He cites the most pressing need as information about the incidence and causes of elder abuse. Without this knowledge, he asserts, intervention is reduced to educated guesses and political compromises.

Schene and Ward (1988) note that once states start to generate accurate and consistent statistics, the magnitude of the problem can be documented. Also, trends in the data will provide a way to measure progress, keep the issue in the public eye, and help set a public policy agenda. Further, data generated will support research and provide the basis for preventive efforts.

2. There is a lack of coordination among the agencies responsible for reporting abuse, investigating and following through on complaints, and developing policy to address elder abuse.

A major weakness of current programs to identify, investigate and curb elder abuse, is that there is little collaboration among the myriad elements of the system. The result is a non-system, with significant instances of overlapping responsibilities, lack of follow-through and gaps between programs.

NARCEA recently identified 30 state level agencies that have roles in elder abuse. In its report on nursing home abuse, the OIG identified at least four state entities that might be involved in the resolution of nursing home residents' complaints. These were: (a) the complaint coordinator; (b) the Ombudsman; (c) the Medicaid Fraud Control Unit; and (d) local law enforcement officials. However, the OIG noted that no single state or federal agency has the responsibility for the overall resolution process.

3. There is a lack of accurate public knowledge about the aging process in general and. the extent and causes of elder abuse.

Obstacles faced in addressing abuse include the public's lack of knowledge about elder abuse and a general lack of knowledge about the elderly and the aging process. The public is usually educated about problems such as elder abuse through media coverage, hearings held by public officials, or a personal experience of a friend or relative. The news media recently provided extensive coverage of elder abuse and Congressional committees also held hearings. While drawing attention to the problem is a vital step, the coverage usually tends toward the sensational. This captures interest on a short-term basis but quickly fades from the front pages. Public education, however, is important and needs to be broadened beyond horror stories to include professional training of those involved in providing services to the aged.

As the population ages, more people are having personal experiences with the problems faced by an aging friend or relative. Identifying with specific cases can help people relate to the needs of the elderly. Unfortunately, the poor understanding that many people have of the aging process supports false assumptions and creates negative attitudes about older people. in turn, these negative attitudes create environments in which elder abuse can readily occur. For example, many people believe diminishing physical and mental capacities are inevitable outcomes of aging. Such attitudes help legitimize behavior such as the widespread use of physical and chemical restraints in nursing facilities. Only recently recognized as forms of abuse, this behavior once represented the norm in dealing with frail elderly people who were believed to be "non-productive and infantile."

Traditional assumptions, now being challenged by more informed research findings, have also helped foster misdirected public policy toward elder abuse. It has been largely accepted that elder abuse is generally committed by younger caretakers, usually against older women, and that most cases do not involve physical violence. Recent research suggests that physical violence is a common form of abuse, that spouses are frequent perpetrators, and that men are as likely to be victims as women. Unfortunately, most state elder abuse statutes and social service programs are based on the traditional assumptions (Wilson, 1989). The result has been resources directed toward portions of the social service system not equipped to deal with the problem.

4. There is a lack of resources to carry out existing mandates.

Most states and jurisdictions have enacted some type of legislation addressing elder abuse; most also have policies and regulations in place to enforce these statutes. Despite the presence of these measures, enforcement is often less than adequate. Many State and local officials contend that they lack the resources that are required to carry out vigorous programs to identify elder abuse situations and intervene on behalf of the victim. In fact, a 1985 survey by NARCEA found that only 11 States appropriate discrete funding to provide services to victims of elder abuse. Further, as many experts

in the field have noted, practitioners may ignore the law because they recognize that there is no service system to address cases of abuse.

5. There is a lack of a uniform definition of elder abuse.

One common issue found in a review of the literature on elder abuse is the serious lack of consensus on a uniform, comprehensive definition of elder abuse. Although many researchers and policymakers include the same categories of behavior in their definition of elder abuse, the meanings of the categories vary considerably. For example, Tanya Johnson (1988) points out that the term "withholding of personal care", has been variously defined as “physical abuse.” “active neglect,” “physical neglect” and "psychological neglect." Other issues also remain unresolved. For example, in dealing with self abuse or self neglect, the issue causes of the of self determination by the elder becomes an essential part of any intervention strategy. Another issue concerns differentiating between intentional and unintentional abuse.

This definitional confusion extends to the laws and protective services statutes that exist in all 50 states. According to Rosalie Wolf (1988), the circumstances leading to the passage of elder abuse legislation were unique in each state. Social and political climates played an important role, and states approached the problem from very different perspectives.

In 1988, NARCEA conducted an analysis of state laws. They confirmed that in most states, “abuse" generally refers to physical harm. But, in some states it also includes psychological harm as well. Some laws include "self abuse" in their definition; others do not. The State laws also vary in what they define as neglect and exploitation.

These disparities in definition have caused a number of problems in the field. From a research perspective, it is difficult to compare findings, develop measurement instruments or explore causal theory. From a legal and public policy perspective, it means that major resources are applied to what is still a vaguely defined social problem, the causes of which remain unclear and the magnitude unknown. From the perspective of the practitioner, everyday decisions become complicated: Is intervention in this case justified? Do I offer services or file criminal charges? As Callahan points out, ultimately definitions shape the total response to the question.