ELDER ABUSE: THE HIDDEN PROBLEM

A BRIEFING

BY THE

SELECT COMMITTEE ON AGING

U.S. HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

FIRST SESSION

JUNE 23, 1979, BOSTON, MASS.

Comm. Pub. No. 96-220

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1980
SELECT COMMITTEE ON AGING

CLAUDE PIPER, Florida, Chairman

HOWARD R. ROYAL, California
MARIO BAGOLI, New York
ISE P. ANDREWS, North Carolina
JOHN L. HURST, California
DON BONER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD B. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MAELLYN LLOYD HODGKINS, Tennessee
JIM SANTING, Nevada
ROBERT F. DRINAN, Massachusetts
DAVID W. BURNS, Indiana
MARTY HIGGINS, Illinois
STANLEY N. LONSDALE, New York
MARY ROSE OAKAR, Ohio
ELIZABETH HOLZMAN, New York
JIM LLOYD, California
THOMAS A. LOCKE, Ohio

CONTENTS

Opening statement of Chairman Robert F. Drinan ........................................ 1
Opening statement of Dr. Thomas H. D. Mahoney, secretary, Department of Elder Affairs, Commonwealth of Massachusetts .............................................. 2

CHRONOLOGICAL LIST OF WITNESSES

James A. Bergman, regional director, Legal Research and Services for the Elderly, Boston, Mass. ................................................................. 3
Suzanne K. Stencel, Ph. D., College of Human Resources, Individual and Family Studies, University of Delaware, prepared statement .................... 7
Marilyn R. Block, director, and Jan D. Sinnot, associate director, Project on the Battered Elder Syndrome, Center on Aging, University of Maryland, prepared statement .................................................. 10
Helen O’Malley, researcher/planner, Legal Research and Services for the Elderly, Boston, Mass. ................................................................. 12
Bryan Langston, director, Family Services Association of Greater Lawrence, Mass. ................................................................. 16
Meridith Savage, regional ombudsman, Department of Aging, State of Connecticut .................. 21
May Hauri, caseworker, Family Services Association of Greater Boston, Mass. ............... 24
Howard Segura, psychologist, Legal Research and Services for the Elderly, Boston, Mass. .... 37
Russ Moran, director, Elder Services of Merrimack Valley, Inc., Mass. ................ 39
Jacqueline Walker, State nursing home ombudsman, Department of Aging, State of Connecticut .................. 33
Karen J. Meyers, attorney, Legal Research and Services for the Elderly, Boston, Mass. ......... 39
Thelma Bailey, associate director, New England Resources Center for Protective Services, Boston, Mass. ................................................................. 43

APPENDICES

Appendix I. Material submitted by James A. Bergman: 46
  Elder Abuse in Massachusetts: A Survey of Professionals and Para-professionals 47
  Elder Abuse: A Review of Recent Literature 71
  With Analysis of Protective Service Systems for Handling Abuse Cases 82
  Recommendations for Abuse Reporting and Handling Legislation 97

Appendix 2. "Testimony on Committee's Elderly Protective Services Law," submitted by Jacqueline Walker ................................................................. 100
ELDER ABUSE: THE HIDDEN PROBLEM

SATURDAY, JUNE 23, 1979
U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Boston, Mass.

The committee met, pursuant to notice, at 9:30 a.m., in room 208,
Suffolk University Law School, 12 Temple Street, Boston, Mass., the
Hon. Robert F. Drinan (acting chairman of the committee) presiding.
Member present: Representative Drinan of Massachusetts.
Staff present: Kathleen Gardner, Professional Staff Member, Select
Committee on Aging.

OPENING STATEMENT OF CHAIRMAN ROBERT F. DRINAN

Mr. DRINAN. The physical abuse of our elderly is a notion that
shocks and disturbs us all. As Mr. Bergman indicated it is one we
don't like to admit exists in our society. When I was advised of the
findings of the Legal Research and Services for the Elderly survey, I
contacted the chairman of the Select Committee on Aging, Congress-
man Pepper, and asked if we could hold a briefing in Boston to gather
more information to compile a report for the committee. He shared
my concern and gave this committee the go ahead.

As indicated, this is the first time that any Congressional Com-
mittee has held hearings dealing exclusively with the physical and
psychological abuse of the elderly. While a number of prominent in-
dividuals and groups have begun to study the situation, there is yet
very little hard information about the topic. We are, in effect, taking
a very important first step here today. It is my hope that this briefing
can increase the public's awareness of the extent of the problem. At
the same time, I hope that we can begin to amass a coherent body of
facts and information in the area of elderly abuse.

Today, we will hear from spokespersons of the Legal Research and
Services for the Elderly project, who will outline the findings of their
survey. All of the evidence and testimony presented here today will be
compiled in a report which I will present to the Select Committee on
Aging. Following the presentation of the report, I and other members
of the Aging Committee will decide what role, if any, that Congress
should play in allaying this situation. I am very pleased to have
present with us today Dr. Thomas Mahoney, the Secretary of the
Massachusetts Office of Elder Affairs. I want him at this time, if he
wishes, to make an opening statement.
OPENING STATEMENT OF DR. THOMAS H. D. MAHONEY, SECRETARY, DEPARTMENT OF ELDER AFFAIRS, COMMONWEALTH OF MASSACHUSETTS

Dr. Mahoney, thank you very much, Congressman. I had the great pleasure of meeting the Congressman a week ago in Washington. The cooperation and help which he extended were something that I will not readily forget. I'm very pleased that my agency saw fit to fund this survey, this body of material that we will be discussing here this morning and I would like to assure one and all that we are very serious about ongoing studies as I'm sure will be pointed out through the course of the day.

We are only at the tip of the iceberg and there is so much we can learn. The findings in this survey are only preliminary but they indicate that elderly abuse is a very serious problem. It is a problem that follows- up is necessary to ascertain where and how abuse cases are uncovered and what methods we should delineate for their handling. The area of abuse or the neglect of elders, unfortunately, could become more prevalent as the years go by and as the problem becomes more and more serious and urgent. It is the intention of your secretary to see to it that a bill will be filed in the coming session of the Massachusetts Legislature for which bills have to be in by early December of 1979. We will be working on a good comprehensive bill to go further into this type of situation and it's perfectly obvious that a service system which is capable of handling the reports would have to co-exist with the reporting law.

Some of the home care agencies, and area agencies on aging have developed or are in the process of developing a service mechanism to intervene when an elder is in danger, when they are unable to protect themselves or when others willingly or unwillingly or when they are unable themselves to deal with one of these situations. This is a service mechanism that falls under the broad category of protective services and usually consists of a Massachusetts social welfare person who serves as a crisis intervention person and also provides coordination of other services as they are needed.

Very briefly, the area of abuse and neglect of elders is a very serious problem for those who are involved. In other words, it is a very serious problem for the abused elders, their families, and for their friends. It is also a matter of great concern to the providers of medical, legal and social services. Issues in recognition of abuse and the treatment for their resolution are, of course, very much undefined at this particular point. Through the Legal Research and Services for the Elderly project, the in-house protective service and committee in the Department of Elder Affairs has already made some preliminary planning strides. During the next six to twelve months, we will be taking a deeper and a harder look at elder abuse. We will endeavor to develop the beginning of a rational, comprehensive effort toward alleviating this terrible problem of abuse or neglect of elders. As many of you know, we are in our infancy in the recognition of this problem. It is only 15 or 20 years ago that child abuse suddenly came upon us as a society. So, as Mr. Bergman said, this is a very, very serious subject. We take no pleasure in the fact that this evidence has been uncovered. We have to be realistic enough to appreciate the fact that it exists. We have to recognize it and we have to do everything in our collective power to rectify it. Mr. Dineen. Will our first witness, Mr. Bergman, please come forward.

STATEMENT OF JAMES A. BERGMAN, REGIONAL DIRECTOR, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LSE)

Mr. Bergman, thank you very much, Congressman. I would like to reiterate one point that was made earlier by Secretary Mahoney. Child abuse was "discovered" to speak in the 1960's and spouse abuse was "uncovered" in the 1970's. I think we're at the point where elder abuse is going to be "discovered." This briefing is especially important because it will focus attention on the fact that elder abuse exists. Furthermore, we saw that generally, spouse abuse was not considered as with child abuse and spouse abuse, until the public policymakers see that elder abuse exists, ways will not be suggested for treating the problem. We saw that generally, spouse abuse was not considered but certainly not widely condemned until women's groups began in the 1970's to make an issue out of it, to call for legislative hearings, to go to the news media and present the fact that wife battering was occurring and in much greater frequency than anyone had ever guessed. I think it was only at that point that women especially and, to a lesser extent, men began to come forward and admit they were in fact being beaten, battered and abused. At that point, as more and more media attention began to be focused on this, as more and more legislative hearings were held, persons were no longer as ashamed as they had been to come forward.

This briefing is certainly a way of beginning to focus more attention, more public attention, more policymaking attention on the problem of elder abuse. This is one of the reasons that we wanted desperately to have a briefing like this—because many older people refuse at this point, as our survey indicated, to come forward and admit that abuse is occurring and is affecting them and that they are being abused. There are any number of reasons that we can surmise why elders don't come forward: shame at being an abuse victim; fear of retaliation by the abuser; belief by the victim that he or she is the major cause of the abuse occurring and, therefore, deserving of what he or she gets. The fact is, no one deserves to be abused. The fact is, no one enjoys being beaten. There seems to be a myth that some people get their kicks out of being abused. I think that we're very misled if we believe that. Circumstances may be set up in such a way that elders feel they can not avoid the abuse; they may face real difficulties in extricating themselves from the abusing situation. But enjoying it? I think that that is not the case at all. It is so important to discuss elder abuse publicly, because it is only then that victims of abuse are likely to come forward to agencies who can, in fact, deal with these issues. Only in this way can elder abuse be addressed effectively. To the extent that this briefing serves to stimulate a public discussion, it will have accomplished its purpose.
Persons who are presenting testimony today will present evidence that elder abuse is much more extensive than any of us thought. They will describe actual cases of abuse that have occurred, that they've dealt with, and the difficulties that each agency has in dealing with those cases. Probably the most difficult cases in the "protective services areas" are those in which an elder has been abused.

Furthermore witnesses will discuss the social work, the ethical and legal issues involved in dealing with elder abuse cases. We hope that this written and verbal testimony today will provide sufficient evidence that the problem is as great as we think it is and will provide a firm foundation for further study and for further action on the problem.

However, throughout this hearing you're going to hear people raising many questions. Indeed, there will be more questions than answers and that's not really surprising—any time an issue is new, everyone dealing with it has much trepidation about going too far, overreacting to the case. We ask why, how, who's doing it? Those are questions which are not going to be answered today. We're only beginning to take a look at these questions. But again, this briefing provides a point for that. As a former Lexington resident once said and I'm paraphrasing, "If the war against elderly abuse is to start, let it begin here."

James Thurber once wrote that there are two kinds of light—the light that illuminates and the glare that obscures. Throughout the last few months as our program has worked on elderly abuse, we've attempted to provide a glow that illuminates the issue; we've attempted very much to avoid the glare of publicity. We know that it's very easy to sensationalize elder abuse. It's a horrifying topic, but the problem with sensationalizing is that you set yourself up for negative reactions. As you will hear today from other persons who testify, most cases of elder abuse are not single instances; abuse is a repetitive act. There are ones that go back years and years in some instances. To think that a fast reaction by a caseworker or public policymaker is going to solve such cases is very wrong. This is one of the reasons we're avoiding in going to sensationalize this issue. We do need a long-term effort to deal with these cases on an individual basis, as well as on a policy basis. Fast knee-jerk reactions are not going to help us address this problem area.

The speakers who follow me will provide much more specific information on individual cases of elder abuse and on research which has been begun in this area, but as an introduction to the problem, I would like to relate one case which I think is a classic. It was, fortunately, handled successfully and also handled properly by the worker, which is something that is not always the case.

This case, I guess, really began about four years ago in central Massachusetts when a young woman and her husband separated and got a divorce. The couple had been living with the husband's mother and had a child of their own. When the couple separated, interestingly enough, the husband left the home but the daughter-in-law stayed there with her child and mother-in-law. The daughter-in-law at that time made the statement to the mother that since she couldn't take out her venom on her ex-husband, she was going to take it out on the woman. Then she proceeded to do so. She periodically beat her mother-in-law and cashed her Social Security check, giving very little back to the elderly woman. The mother-in-law also suffered mental anguish. The daughter-in-law had alcohol problems and was using a good portion of the money for alcohol. The older woman was obviously in a very difficult situation. Fortunately, about four months ago, a neighbor called the Visiting Nurse Association and indicated that the house had deteriorated substantially, and they thought that maybe the older woman was having health problems as a result of it.

When the nurse went to the home she discovered not only health problems but also what looked like a potential case of abuse. She called the protective services worker of the Home Care Corporation in that area. Fortunately, that Home Care Corporation is one of the few in the state that has a protective services program. Had it not been for that, this story would have had, I think, a very different ending. But the protective services worker went in, established in her mind that abuse was in fact occurring, that malnutrition was occurring and talked with the elderly woman about it. She established a relationship with her but was not able to convince the woman that she ought to do anything about the situation itself. The worker was able to convince her that medical treatment was necessary but was not able to get any further than that. The worker spent considerable time over the next four months working with that older woman, talking to her, establishing a relationship with her, but was still not able to convince her to take any action to protect herself. Finally, about a month and a half ago, the landlord threatened to evict everybody from the house. They had to leave the home because the house was so poorly cared for, so deteriorated. Threatened with eviction, the older woman finally said she would act. If her choices were to be thrown out on the street or to refrain from abusing the older person, she decided she would leave the house by herself, then she decided she would take the latter course.

At that point, the protective services worker contacted the legal services attorney for the elderly in that area. That attorney, representing the older woman, went into court and got a vacate order which required the daughter-in-law to leave the premises immediately as well as to refrain from abusing the older person. At that point, the daughter-in-law was forced to leave the home, did so, and was given an opportunity for a hearing. She did not contest the order and it was made permanent for a year.

That could have been the end of the story. Fortunately, again, this was a situation where the Home Care Corporation and the older agencies in the community had been dealing with the case over a long period of time and immediately brought in extra services to provide some support for that elderly woman, now living alone in the house. She got homemaker's service, chore service to help clean up the house, transportation to medical care, and was advised of the continued availability of legal services if the daughter-in-law should violate the court order. The visiting nurse and the protective services worker continued to go into the home on a very regular basis. Davis after that
vacate order was issued, the woman was still having great fear about what would happen around 4 or 5 in the afternoon which was the normal time for the daughter-in-law to come home from work. She has not come home, however, and now, 3 or 4 weeks later, the woman seems to be getting used to the situation, and seems to be getting along nicely. Her blood pressure, which was elevated and at a very dangerous level, is now working its way slowly back down and it appears that the situation will have worked out very nicely.

This case illustrates some general findings that we've made on elder abuse. In this case, as in many others, the older person was not very mobile; she was somewhat dependent upon the person who was abusing her; she was being financially exploited; she was being beaten as well as mentally abused and the abuser herself also had a very serious problem—alcoholism. The abuse continued for a very long period of time. We also see that the victim was not the person who reported the abuse case. It was a third party, a neighbor. The victim did not want to do anything about that abuse situation initially. It took extended time and contacts with workers before the elder agreed to protect herself and the workers were not being kept in contact. It is unlikely that the victim probably would have occurred and the situation would undoubtedly not have improved at all.

These factors appear to typify many abuse cases as other speakers will relate today. I think the thing that's not typical about this case is that it was successfully resolved. That is not at all typical of cases of this nature.

Many of the remedies for elder abuse cases must originate with state and local action and that will again be discussed by many other speakers today so I won't dwell on it. I would like to suggest three steps that I think can and should be taken at the federal level.

One, I hope that as a result of this briefing today, the House Select Committee on Aging will conduct further hearings to be held in Washington and across the country which will probe this is a nation-wide problem and the more attention that can be focused on it, the more information that can be gathered, the better all of us are going to be in terms of being able to respond to it.

Second, since elder abuse is just being uncovered, much more research is needed as well as special projects to test various methods of locating persons who are being abused and of actually handling these cases. If it is possible, the Congress should try to encourage both the Administration on Aging, the National Institute on Aging and possibly the Law Enforcement Assistance Administration to begin targeting some of their resources to issues of elder abuse.

Third, Title XX of the Social Security Act provides normally 75% federal reimbursement for social services provided through state and local agencies under contract. Since the scope of elder abuse is still unknown, it seems to me to be premature to recommend that Congress mandate that all states develop extensive programs to prevent elder abuse. However, I think it is appropriate at this point for Congress to amend Title XX of the Social Security Act to provide encouragement to the states to set up services which would treat and prevent elder abuse. That could be done by changing the reimbursement program from 75% federal dollars to 90% federal dollars. In that way, states would not be mandated to set up these programs but certainly there would be a financial incentive-incentive for them to do so.

These are not intended to be extensive recommendations by any means but I think they are reasonable at this time. Before closing, I would like to submit to the record the written statements of the authorities on elder abuse who are unable to be here today. First, the Commissioner of the Administration on Aging and testimony of Dr. Marilyn E. Block and Dr. James Sinnott of the University of Maryland.

Thank you very much.

[The prepared statements of Dr. Steinmetz, Dr. Block, and Dr. Sinnott follow:]

PREPARED STATEMENT OF SUZANNE K. STEINMETZ, PH.D., UNIVERSITY OF DELAWARE, COLLEGE OF HUMAN RESOURCES, INDUSTRIAL AND FAMILY STUDIES

A 74-year-old widow who broke her arm in a fall is invited to move into her son and daughter-in-law's home, only to find she is confined to a basement. At one time she tried to come upstairs, her daughter-in-law physically forced her back down and then severely twisted her hair by her arm. The victim is an invasion with an unanticipated foot, has a son that has been involved in a lot of trouble, and had violent episodes. She has called the State Police and signed a warrant but could not show up in court because of her condition. The son now has a gun and is threatening her.

In a drunken rage a middle-aged man beats his 67-year-old step-mother into unconsciousness with a metal pitcher. Admitted to the hospital where she is to stay for a month, she requires transfusion, multiple antibiotics of lacrimation, numerous X-rays, orthopedic and neurosurgical attention.

We know from our studies of child abuse and wife beating that sensational cases while attracting public attention represents a very small proportion of the total abuse in this area. We recall in horror the story of the child who has had boiling water thrown on him or the infant who had lighted cigarettes pushed into a warrant but could not show up in court because of her condition. The son now has a gun and is threatening her.

As a society we seem to be more concerned with the visible outcome, the extent of bodily injury but not concerned with the underlying assault. By removing those instances of normal acceptable violence towards a child represents the majority of child abuse incidents.

My concern with this problem lies in the battering which takes place in general, and battering within families; those families in which the elderly parent is dependent on the child generation for emotional, financial, physical or mental support. In these families it is not just role reversal, but the entire set of generational linked rights, responsibilities which are reversed.

Discussing the familial acts of abuse against elderly, holds our public attention but allows us to overlook the problems which occur in our own backyards. Thus we recall in horror from newspaper accounts of abuse against elderly, and yet fail quite on extensive programs to prevent elder abuse. However, I think it is appropriate at this point to recommend that Congress to amend Title XX of the Social Security Act to provide encouragement to the states to set up services which would treat and prevent elder abuse. That could be done by changing the reimbursement program from 75% federal dollars to 90% federal dollars. In that way, states would not be mandated to set up these programs but certainly there would be a financial incentive-incentive for them to do so.

These are not intended to be extensive recommendations by any means but I think they are reasonable at this time. Before closing, I would like to submit to the record the written statements of the authorities on elder abuse who are unable to be here today. First, the Commissioner of the Administration on Aging and testimony of Dr. Marilyn E. Block and Dr. James Sinnott of the University of Maryland.

Thank you very much.
about the battering child and the family and by this mechanism gain some insights into families where the parent is being battered. First, in both of these instances, the victim is in a dependent position in the care of the elderly person or formalized care for basic survival needs. Second, in American society we assume that one of the major roles of the family is to provide an environment for its members characterized by gentleness, loving, caring and emotional support. Finally, both the dependent child and the dependent elderly adult are often seen as sources of emotional, physical and financial stress to the caretaker. While the cost of caring for one's children is at least a recognized reality and is provided for in direct grants, public schooling, and tax deductions, the emotional and economic responsibilities for the care of one's elderly parents over a prolonged period of time has not yet been fully acknowledged.

(5) Often, when we talk about problems occurring within the family it is very easy for individuals to suggest that in the past the family took care of their elderly. It is important then to put this problem in a historical perspective.

First, it must be recognized that life expectancy has increased tremendously. Thus, we have a larger number of people reaching the vulnerable elderly stage (60 or older) than have occurred in any other family relative to the population. Second, we have for the first time a large number of people who are living beyond their economically productive years. Economically productive years are defined in contemporary society as maintaining full time paid employment. With retirement occurring between the ages of 60 and 65 (although it is extended to the present type of social security), the probability of an increasing number of people now face a decade or so in which they are forced to live on fixed incomes. However, it is not the financial arrangements which have altered.

Since the major identity in our society is one's work role, these individuals lose status, power and the prestige that goes with being an economically productive member of society.

Thus, the advent of antibiotics in the early 1940's and major medical advances in the 50's, 60's and 70's has resulted in a large number of people living to old age in a physically deteriorating condition. In the past, survival of the fittest was a reality. Even such a common occurrence as the flu was likely to be the death itself for any but the strongest elderly individuals.

If we examine demographic patterns, we become aware that the old expression "as West young men, go West" was, in reality, the pattern followed by emigration after generation after generation. First, there were settlers from Europe who emigrated to the Eastern shores and then each succeeding generation continued the move westward. We know that the three generational family, which had been the model and exemplified in the television series, The Waltons, was for the most part the prevailing pattern of residence. It existed for only a brief period of time among families with large agricultural holdings. Obviously, those who moved west were the young and healthy, the elite of society.

Thus, any three generational pattern found was likely to be for very brief periods of time when the young married couple was building their new home or when the elderly individual had moved to die. Thus, for the first time in history, we have a large number of elderly individuals in a dependent situation. The pattern was also changing their own real estate. The elder was forced to rely on his or her own money for extended periods of time. The elder was dependent on his or her own physical, emotional and financial aid and was already dependent for immediate intervention, the kinds of physical and emotional abuse which are most elderly people are experiencing as more as never. Yet those are not addressed if we are to prevent many of these families from deteriorating into potential abuse situations.

We need to provide a mechanism for supply resources to families who assume the role of the elderly persons. The government response must have taken this situation into account if there is to be a recognition of the stressors, the prolonged and severe type of dependency which may result in more than the family alone can cope with. We need to also recognize that this family may consist of a couple (or individuals) who are not responsible for their own children and grandchildren, but are likely to be in the process of making plans for their own impending retirement.

The type of resources needed are such things as extending the meals on wheels service, providing homemakers, require care day care and financial help, there is just not enough money over the additional expenses required. There may be modifications or reconstructions needed in the housing, there may be special hospital beds, walkers and hospital type equipment required in order to care for the elderly person.

Education plays a very important part in this process. Few of us have had either informal experience in the care of the elderly person or formalized experience in this area. Thus, the decision to assume the responsibility for an elderly person is often made in an environment for its members characterized by gentleness, loving, caring and emotional support.

In addition, to education is the need for providing counseling to families who are responsible for an elderly person. Very often the dependent parent conflicts of 60's parents have still not been resolved and the impetus for the child to leave home is because of these unresolved conflicts. We also know that in many families the only contact is the obligatory Christmas or Easter visit during which relations are strained and filled with guilt, resentment and tension.

Given this background, it is easy to understand the emotions which the adult child, who has been faced with the reality of assuming responsibility for his or her parent.

If the relationship was a positive one throughout these years, the increasing of the generations and the evening responsibilities and obligations this evening, any care help very often needs some time (although it is extended to the present type of social security) for the elder person is a woman, to realize that she is not the head of this household and that she has the legitimate right to control activities such as what she does daily or weekly. Even the relationship where the daughter who may feel ambibity about her role as a child or her role as a caretaker, needs to have support in setting down certain family guidelines. This is necessary to avoid the disruption of family harmony. This counseling helps both parties to understand their own role relationship.

For example, the daughter who has never been able to please her mother may not find the latter's comments about her cooking being tasteless more than she can bear. Yet if she realizes that because of the aging process and the biology of cooking, which is the need for providing counseling to families who are responsible for an elderly person. Very often the dependent parent conflicts of 60's parents have still not been resolved and the impetus for the child to leave home is because of these unresolved conflicts. We also know that in many families the only contact is the obligatory Christmas or Easter visit during which relations are strained and filled with guilt, resentment and tension.

Given this background, it is easy to understand the emotions which the adult child, who has been faced with the reality of assuming responsibility for his or her parent.

If the relationship was a positive one throughout these years, the increasing of the generations and the evening responsibilities and obligations this evening, any care help very often needs some time (although it is extended to the present type of social security) for the elder person is a woman, to realize that she is not the head of this household and that she has the legitimate right to control activities such as what she does daily or weekly. Even the relationship where the daughter who may feel ambibity about her role as a child or her role as a caretaker, needs to have support in setting down certain family guidelines. This is necessary to avoid the disruption of family harmony. This counseling helps both parties to understand their own role relationship.

For example, the daughter who has never been able to please her mother may not find the latter's comments about her cooking being tasteless more than she can bear. Yet if she realizes that because of the aging process and the biology of cooking, which is the need for providing counseling to families who are responsible for an elderly person. Very often the dependent parent conflicts of 60's parents have still not been resolved and the impetus for the child to leave home is because of these unresolved conflicts. We also know that in many families the only contact is the obligatory Christmas or Easter visit during which relations are strained and filled with guilt, resentment and tension.

Given this background, it is easy to understand the emotions which the adult child, who has been faced with the reality of assuming responsibility for his or her parent.

If the relationship was a positive one throughout these years, the increasing of the generations and the evening responsibilities and obligations this evening, any care help very often needs some time (although it is extended to the present type of social security) for the elder person is a woman, to realize that she is not the head of this household and that she has the legitimate right to control activities such as what she does daily or weekly. Even the relationship where the daughter who may feel ambibity about her role as a child or her role as a caretaker, needs to have support in setting down certain family guidelines. This is necessary to avoid the disruption of family harmony. This counseling helps both parties to understand their own role relationship.

For example, the daughter who has never been able to please her mother may not find the latter's comments about her cooking being tasteless more than she can bear. Yet if she realizes that because of the aging process and the biology of cooking, which is the need for providing counseling to families who are responsible for an elderly person. Very often the dependent parent conflicts of 60's parents have still not been resolved and the impetus for the child to leave home is because of these unresolved conflicts. We also know that in many families the only contact is the obligatory Christmas or Easter visit during which relations are strained and filled with guilt, resentment and tension.

Given this background, it is easy to understand the emotions which the adult child, who has been faced with the reality of assuming responsibility for his or her parent.

If the relationship was a positive one throughout these years, the increasing of the generations and the evening responsibilities and obligations this evening, any care help very often needs some time (although it is extended to the present type of social security) for the elder person is a woman, to realize that she is not the head of this household and that she has the legitimate right to control activities such as what she does daily or weekly. Even the relationship where the daughter who may feel ambibity about her role as a child or her role as a caretaker, needs to have support in setting down certain family guidelines. This is necessary to avoid the disruption of family harmony. This counseling helps both parties to understand their own role relationship.

For example, the daughter who has never been able to please her mother may not find the latter's comments about her cooking being tasteless more than she can bear. Yet if she realizes that because of the aging process and the biology of cooking, which is the need for providing counseling to families who are responsible for an elderly person. Very often the dependent parent conflicts of 60's parents have still not been resolved and the impetus for the child to leave home is because of these unresolved conflicts. We also know that in many families the only contact is the obligatory Christmas or Easter visit during which relations are strained and filled with guilt, resentment and tension.

Given this background, it is easy to understand the emotions which the adult child, who has been faced with the reality of assuming responsibility for his or her parent.

If the relationship was a positive one throughout these years, the increasing of the generations and the evening responsibilities and obligations this evening, any care help very often needs some time (although it is extended to the present type of social security) for the elder person is a woman, to realize that she is not the head of this household and that she has the legitimate right to control activities such as what she does daily or weekly. Even the relationship where the daughter who may feel ambibity about her role as a child or her role as a caretaker, needs to have support in setting down certain family guidelines. This is necessary to avoid the disruption of family harmony. This counseling helps both parties to understand their own role relationship.
How this is going to impact on the family caring for an elderly person is not known, but one can predict that the smaller the amount of money available for luxuries, the smaller the amount of money there will be to provide older sits or housekeepers or some of the other resources which might alleviate some of the stresses. The final thing that needs to be considered is that the working woman is a growing phenomenon. In many instances, women are returning to work after their children have left the house to meet some of the additional expenses to maintain the standard of living they have enjoyed. We find in some cases women are faced with situations of "If I work, who will take care of mother?", and yet if they don't work how can they meet their monthly bills? With increased conflict between the needs of parents and the goals of the children, we can predict an increase in the amount of violence children use to control their elderly parents unless adequate support systems are available.

Prepared Statement of Marilyn R. Block, Director, and Jan D. Sennott, Associate Director, Project on the Battered Elder Syndrome, Center on Aging, University of Maryland

Violence in the family setting, when considered at all, is usually viewed as an abnormality. The family is often conceptualized as a haven, a place to escape the stresses of the outside world. The definition of violence, however, is not limited to just physical abuse. Other types of violence, such as psychological violence, are not generally recognized, nor are they the subject of much scholarly research. The problem of violence against the elderly, however, is a well recognized social phenomenon which has been referred to by various descriptors, among them "granmy-bashing" and "grand-slamming." Despite the various labels, the grim truth is that there is an increasing evidence that middle-aged adult children are physically and psychologically abusing their aging parents in a manner analogous to child abuse. Situations where the older person is victimized by family members will, in all probability, increase as greater numbers of parents live into old age and require care from their children.

Incidence of Elder Abuse

There are no statistics to document the scope of parental abuse by adult children, since there have been no studies of the problem. An article in the Cleveland Plain Dealer (March 5, 1978) mentions a Stanford University report which notes that many middle-aged middle-class women know of cases where children have abused their parents. William J. Brown has published a task force study to detect domestic violence and has gone on record indicating his belief that victims of elder abuse number in the thousands. The State of Connecticut recently passed an elderly protective service law which may be a first step. The problem of the elderly who have some form of impairment and are therefore vulnerable to their children needs to be addressed. There is a need for more educational efforts to increase the awareness of the problem.

Nature of Elder Abuse

Isolated descriptions of abuse form the bulk of the information concerning the incidence of the abuse that adult children inflict on their aging parents. Extremely little research has been carried out. Abused elders generally suffer from more than one form of abuse. The majority of descriptive cases reported by various sources involve both physical abuse and psychological abuse. Other forms of abuse include theft or misuse of money or property, forced departure from the family home, and forced entry into a nursing home.

Potential Causes of Abuse

The problem of elderly abuse has many dimensions, and information concerning these dimensions is rare. How the various factors interact to create specific situations of abuse will only be discovered through further intensive research efforts.

Characteristics of the Abused Elder

There is extremely limited information describing abused elders. Those who have some form of impairment of family as a source of violence. A study of elder abuse in Cleveland found that over three-fourths of the victims had at least one major physical or mental impairment (Jan and Kocberg, 1978).

Infants tend to deny that abuse has taken place, which is one reason that the battered elder syndrome is so difficult to document. They may fear being removed from the family setting even more than the abuse itself. Refusal to report incidents of abuse to authorities may also stem from the fear of retaliation, the shame of admitting to such treatment by their own children, or the lack of alternative living arrangements.

Potential Causes of Abuse

The problem of elderly abuse has many dimensions, and information concerning these dimensions is rare. How the various factors interact to create specific situations of abuse will only be discovered through further intensive research efforts.
vital needs. Both reside in a family setting that is assumed to provide love and caring protection. Both are sources of emotional, physical, and financial stress to the caretaker.

Our current research, funded by the Administration on Aging, is designed to assess the extent of the problem of elder abuse and to develop partial answers to the question “Why does elder abuse occur?” We also are attempting to develop models which describe different types of maltreatment of older persons and which clearly delineate the situational and personal factors involved. A fourth goal is to develop three approaches suitable for obtaining data on abuse and to compare those approaches in terms of feasibility, adequacy, cost, and usefulness for policy and program development. This data will come from agencies which serve the elderly, from a selected sample of professionals, and from a sample of older individuals living in the community. Analysis of this information is now underway. It should provide direction to those who must deal directly with the elderly suffering abuse.

Mr. Dineen. Thank you very much, Mr. Bergman, for a very fine presentation. The next speaker will be Helen O'Malley, Researcher and Planner for LRSE.

STATEMENT OF HELEN O'MALLEY, RESEARCH/PANNER, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LRSE)

Mrs. O'MALLEY. Good morning. My name is Helen O'Malley and I am on the staff of the Legal Research and Services for the Elderly. Legal Research has been funded by the Massachusetts Department of Elder Affairs to study elder abuse. As part of that study, we were responsible for conducting a statewide survey of professionals and para-professionals who we thought might have seen elder abuse over the past 18 months. That survey was conducted in March and April of this year. I'd like to describe that survey and present you with some of the findings that we think may be important in helping us to understand and recognize these cases. I also have a copy of the survey which I'd like to enter into the record of this briefing.

(See appendix 1, p. 47 for survey.)

In our survey, we defined abuse as “willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker of services which are necessary to maintain the physical or mental health of the elder.” We defined elder to be anyone 60 years of age or older, living at home either alone or with family or friends. Clearly, we were not looking at institutionalized abuse which is something that receives attention now. We were looking for something even more hidden—abuse in the home. Also, as you can see from the definition, we gave abuse a rather broad meaning. We included some aspects of what most people would call neglect. We did specify, however, that the neglect or deprivation of services had to be willful in nature. What we were looking for were older people who were deliberately hurt in their homes by someone else.

We sent out over 1,000 surveys to medical people, social services professionals and para-professionals. We were trying to find out five things: who sees elder abuse, what are some characteristics of abused persons, what does the abuse look like, what injuries were sustained and what was done about it. When we analyzed the surveys returned to us, we found that 183 reported a citing of elder abuse in the past 18 months. That doesn't mean that we uncovered 183 individual cases of elder abuse because two or more people could have been reporting on the same case. But, certainly we found that a sizable number of people were seeing or hearing about abuse or suspected abuse. Before I go on and present our findings to you I'd like to explain some of the limitations of this kind of survey. The survey was designed to give us descriptive information only. We didn't use random sampling techniques; we have potentially duplicated cases, as I mentioned. That means that anything we uncovered through this survey has to be validated by additional research. Let me give you our findings.

First, we found that almost every profession we surveyed has come into contact with elder abuse or suspected elder abuse. Visiting nurses, Home Care Corporation staff, hospital social services directors and home health aide staff account for most of the citations. Certainly, as we begin to construct our systems for identifying elder abuse, these professionals should play key roles in identifying potential cases.

Perhaps one of our most important findings was that abuse tended to happen again and again to the same person. In 70% of the citations, abuse occurred more than twice and in an additional 8% of the citations, the abuse occurred at least twice. While our survey doesn't permit us to estimate the incidents of abuse, demographic trends towards an increasingly larger elder population and our findings on the recurrent nature of abuse, make it likely that we'll be seeing more rather than less of this problem in coming years.

Who's being abused? We found that abuse occurred in all age groups from 60 to 80 and over. But the 75 and over age groups seemed to account for more of the citations that we would normally expect. We also found that women tended to be victims of abuse more often than men in all age categories. This held true even when we controlled for the proportionately greater number of women than men in the elder population. 80% of the 183 survey citations said the victim was female. Looking at these findings on age and sex, we can begin to form a picture of the abused elder as someone who is likely to be quite old and who is likely to be a woman. We also found in 3/4 of the citations that the abused person had some physical or mental disability that prevented him or her from meeting daily needs. We found that in 75% of the citations, the victim lived with the abuser and that in over 80% of the citations, the abuser was a relative. As one of our staff people said, "It looks as if abuse, like charity, begins at home." The data seems to indicate that disabled or frail elderly who live at home with their relatives are prime targets for abuse.

The survey also told us something about the abuser. Almost 3/4 of the survey said the abuser was experiencing some kind of stress such as alcoholism, drug addiction, a medical problem or a long term financial problem. The elderly victim was often cited as a source of stress to the abuser, primarily because the elder required a great deal of physical and emotional care from the abuser or was financially dependent on the abuser.

These findings of stress experienced by the abuser and the levels of disability of the victim are important because they give us some feeling for the factors that may be at work in the abusive situation. We know from studies on child abuse that abusing tends to occur in families that
are under a great deal of stress. At least there's some indication that this is so. Is it possible that stress can be a factor in elder abuse as well? Does the stress of caring for an aging or disabled parent sometimes become so great that abuse occurs? Our survey certainly cannot answer that question but the high percentages of both disability and stress uncovered by the survey indicate that we should look a lot more closely at those two factors in future research and as we try to deal with this form of abuse.

We were interested in finding out what the abuse looked like to see if there were any physical signs that doctors or other professionals could begin to look for as they were dealing with these cases. We found that in most of the cited cases, the elder suffered some form of physical trauma, such as bruises, welts, sprains or fractures. Most of the trauma described in the survey was minor in nature from a medical point of view, but major traumas did occur, including fractures. Other types of abuse were described such as verbal harassment, malnutrition, financial mismanagement, unreasonable confinement, sexual violence and sexual assault. But, certainly, the great majority of citations were primarily situations in which the elder was physically battered in some way.

We also asked questions in the survey about how suspected abuse had been uncovered and what had been done about it. We found that the abuse had usually been brought to the attention of the person answering the survey by someone other than the victim or relative of the victim—70 percent of the abuse cited in a third party as the reporter of abuse. Interestingly, one of the chief barriers to service provisions that respondents cited was this same unwillingness of the victim to admit that abuse had occurred or to accept services or help in dealing with the problem. Fear of retribution, our inability to protect the elder from further abuse and the shame and guilt which elders feel in discussing this problem make it very difficult for workers to deal with this kind of abuse.

Finally, we found that a wide variety of intervention strategies were used by respondents. Some respondents chose to confront the abuser and arrange for follow-up or back-up services. Others called in multi-disciplinary protective service teams to provide services for the victim, the abuser and the family. The survey doesn't permit us to assess the appropriateness of these interventions but it clearly points out the disparity among respondents in the skills and services which are being brought to bear in cases of elder abuse. Most workers try to deal with the problem when they see it but few systems are in place to help them manage these very difficult cases. Some of the other speakers this morning will discuss ways in which we can begin addressing the problem of elder abuse.

Mrs. O'Malley, I think that is quite likely. We did put something in the definition called deprivation of services or "neglect" which is not quite the same as "physical abuse." But we did try to limit the definition somewhat by specifying that the neglect had to be willful in nature.

To check on the number of actual batterings, we went through our surveys and looked at the section where we asked people to write a brief description of the abuse. In well over half of those surveys, the problem was what appeared to be willful battering of the older person. In only 30 of the 183 citations was verbal harassment or financial mismanagement the main problem. So I think that even though our definition is broad, we did capture reports that primarily describe physical abuse. I also think that in initial studies of this nature, a broad definition is useful in helping us see what is going on in the world. We found very serious problems and we did find, in at least half of the citations, physical battering.

Dr. Mahoney, is there any indication in the survey that the people who were me in child abuse or spouse abuse are also likely to commit elder abuse?

Mrs. O'Malley. Not from our survey. We tried to ask that question but I think the question was phrased improperly and we just couldn't understand the findings that we were getting. There are other people, such as Suzanne Steinmetz, whom Jim Bergman mentioned before, who are doing research on other forms of family violence and there does seem to be some indication that different kinds of violence can be going on in the same family. Also, that violence can be passed on from one generation to another. If you are an adult and as a child you were battered, you are likely to be battered as an adult. In families where child abuse is going on, the child is much more likely to strike at a parent than in families where no abuse is going on. Dr. Mahoney. Something close to that, I could not quite decode from the data, the percentage of people who abuse who have a personal problem. The majority of the people who abuse do, in fact, have a problem in almost all instances. Mrs. O'Malley. I remember that figure. I think it was about 63 percent of those abusers had some kind of stress related problem according to the person who was filling out the survey. Some of those problems were alcoholism, drug addiction, loss of job, long term financial problems, or other problems. I think we really need to look at those findings much more carefully. Some studies, for example, have shown that alcoholism is one determinant of violence.
surveyed, the relatives happened to be the ones taking care of the victim.

Dr. Mahoney. Well, another thing comes to mind. Did the people who completed the survey find that there were other problems in dealing with abuse besides the unwillingness of the abused to testify or seek help?

Mrs. O'Malley. Yes, the people who filled out the survey did say that they were confronted with other kinds of problems: two basic problems, both of which I think were hit on in Brian's testimony. One is the problem of access, getting through that door, feeling that they have no legal responsibility or right to intervene in an abusive situation unless they have a complaining witness and we know that older people sometimes are afraid or unwilling to complain. That's the first kind of problem. The second one that the people who filled out the survey cited was the lack of certain kinds of services they felt they could have used. In many of the surveys, the people said they had to place the abused person in a hospital or nursing home when they would rather have used some kind of temporary housing facility or emergency housing facility for that person until the abuse situation could be worked through. In Massachusetts, we do have shelters for abused women and their children. Most of these, however, aren't set up to deal with the disabled elderly person. You have to be ambulatory to get into those shelters and that's a real problem.

Dr. Mahoney. There are really programs for battered spouses.

Mrs. O'Malley. That's right. So we don't have shelters for older people that would provide some kind of care for them until the abuser can receive some counseling or until the emergency is past and long-term plans can be made. As a result, people end up temporarily or perhaps permanently in nursing homes when they would rather have used some kind of temporary housing facility or emergency housing facility for that person until the abuse situation could be worked through. In other instances, the older person felt there was a need for more protective and counseling services for elderly in the Merrimack Valley. The remainder of the referrals come from landlords, neighbors, from councilors on aging and other social agencies. During the 12 month period from March 1, 1978 when we began this project until the end of February 1979, there were 82 cases referred to the program. The clients ranged in age from 60 years old to 99 years old and about one half between ages 80 and 90. Looking at one-quarter of the last quarter of the first year, we served 80 active cases during that three month period from December 1978 until the end of February 1979. Of those 80 cases, 8 were suspected of abuse by a family member, 4 were suspected of being physically abused by a non-relative and 3 were referred for possible neglect by family in cases of physically dependent elders. However, once we got out into assessing those cases, the clinical social workers assigned to the protective and counseling services project found in their own follow-up that of the 80 cases, 21 were experiencing harm or were seriously threatened with harm by the actions of other individuals upon whom they were dependent. In many of these cases, the primary reason for referral had not been suspected abuse and neglect but rather had been for reasons of confused or disoriented behavior of the elderly person which someone had observed for poor housing or because the referral source felt there was a need for more supportive services to the older and the elder was resistant or the family was resistant to accept that.

Physical and emotional abuse of elderly persons is sometimes very, very difficult to document. Pleas for help or requests for intervention are frequently interdenied by the elderly themselves. Physical and emotional dependence and fears of retaliation by caretakers are important factors. Many elderly persons fear separation from their homes and familiar surroundings. Because of this, they resist telling outsiders what may be really happening. In other instances, the older person's family is resistant to any community intervention. The family or the important caretakers for the older person will block intervention by such tactics as threatening legal suits for trespassing on their property. Protective services programs for elderly do not have a clear mandated authority as to programs for children to investigate and follow-up on suspected abuse or neglect. Staffs on elderly programs are in a very gray and foggy area when it comes to intervening in these kinds of situations.

CAUSES FOR ABUSE AND NEGLECT OF ELDERLY: The abuse or neglect of elderly persons by their families seems to us to fall into several broad categories. First, are those families where their emotional, physical and even financial resources are depleted in their efforts to care for frail, elderly persons. In these situations, the elderly person may be confined to bed at home, confused, incompetent, wandering at night. Most of these families have been fairly well adjusted and have a strong sense of obligation to care for their elderly family member at home. These are families that if you met them, you would believe they had a very strong sense of commitment to their own. But the burden has become too much and the family is overwhelmed. They are caught in a conflict of the values. Second are the families where past, unresolved family conflicts become reac-

STATEMENT OF BRIAN LANGDON, DIRECTOR, FAMILY SERVICES ASSOCIATION OF GREATER LAWRENCE, MASS.

Mr. Langdon. Thank you, Mr. Chairman. My name is Brian Langdon and I am Executive Director of the Family Services Association of Greater Lawrence. My agency and two other family service agencies in the Merrimack Valley, Family Service of Lowell and Children's Aid and Family Society of Haverhill, together have a jointly funded project to provide protective and counseling services for elderly in the Merrimack Valley. This specialized program is funded by Title 3 under the Older American's Act and reaches frail, elderly persons who are suspected to be in a situation that is dangerous physically and/or psychologically to them.

About one half of the referrals that come to our project come from visiting nurses, public health nurses. About one-quarter of the referrals come from the Merrimack Valley Elder Service which is our Home Care Agency, in the Merrimack Valley. The remainder of the referrals come from landlords, neighbors, from counselors on aging and other social agencies. During the 12 month period from March 1, 1978 when we began this project until the end of February 1979, there were 82 cases referred to the program. The clients ranged in age from 60 years old to 99 years old and about one half between ages 80 and 90. Looking at one-quarter of the last quarter of the first year, we served 80 active cases during that three month period from December 1978 until the end of February 1979. Of those 80 cases, 8 were suspected of abuse by a family member, 4 were suspected of being physically abused by a non-relative and 3 were referred for possible neglect by family in cases of physically dependent elders. However, once we got out into assessing those cases, the clinical social workers assigned to the protective and counseling services project found in their own follow-up that of the 80 cases, 21 were experiencing harm or were seriously threatened with harm by the actions of other individuals upon whom they were dependent. In many of these cases, the primary reason for referral had not been suspected abuse and neglect but rather had been for reasons of confused or disoriented behavior of the elderly person which someone had observed for poor housing or because the referral source felt there was a need for more supportive services to the elder and the elder was resistant or the family was resistant to accept that.

Physical and emotional abuse of elderly persons is sometimes very, very difficult to document. Pleas for help or requests for intervention are frequently interdenied by the elderly themselves. Physical and emotional dependence and fears of retaliation by caretakers are important factors. Many elderly persons fear separation from their homes and familiar surroundings. Because of this, they resist telling outsiders what may be really happening. In other instances, the older person's family is resistant to any community intervention. The family or the important caretakers for the older person will block intervention by such tactics as threatening legal suits for trespassing on their property. Protective services programs for elderly do not have a clear mandated authority as to programs for children to investigate and follow-up on suspected abuse or neglect. Staffs on elderly programs are in a very gray and foggy area when it comes to intervening in these kinds of situations.

CAUSES FOR ABUSE AND NEGLECT OF ELDERLY: The abuse or neglect of elderly persons by their families seems to us to fall into several broad categories. First, are those families where their emotional, physical and even financial resources are depleted in their efforts to care for frail, elderly persons. In these situations, the elderly person may be confined to bed at home, confused, incompetent, wandering at night. Most of these families have been fairly well adjusted and have a strong sense of obligation to care for their elderly family member at home. These are families that if you met them, you would believe they had a very strong sense of commitment to their own. But the burden has become too much and the family is overwhelmed. They are caught in a conflict of the values. Second are the families where past, unresolved family conflicts become reac-
tivated during the stress of caring for an elderly family member or where the elderly person’s increased dependency needs lowers their own abilities to protect themselves from longstanding anger and resentment of another family member. Frequently, in such instances the older person’s financial resources are abused. Sibling’s battle over property and other person does not get the services and help which, in many of these instances, he or she certainly needs and to which he/she may be eligible and often can afford.

Third, are those families which have long histories of poor adjustment in the community. Frequently, these situations involve a very emotionally disturbed family with paranoid family members and usually the family member who is caring for the elderly relative is herself very disturbed. They are suspicious of other people and remain isolated from neighbors and others in the community. They angrily and directly reject any outside help and usually deny any need for assistance at all.

The fourth category involves those elderly who are victims of abuse or neglect because of the failure of the community to provide sufficient support and help to their families. These are families that are really victims in that any of us could find ourselves. These situations include elderly persons needing custodial care who are discharged home from acute care hospitals because nursing home beds are not available.

It involves families where homemaker, home health aide services are needed but not available several hours a day, seven days a week. It includes older persons who need a limited guardianship or conservatorship and cannot afford such services.

I’d like to share with you briefly four case examples which I think document each of these types of abuse and neglect. First, Mrs. D. was 84-year-old lady who lived alone with her son whom she had cared for all his life. Her husband died 25 years ago and except for an elderly cousins in Canada there is no other living family. They have managed to take care of themselves successfully until three months ago when Mrs. G. fell and lived her back and was hospitalized. After one week in the hospital she was discharged home. She was unable to walk. She stayed in bed and her son tried to care of her and feed her. He would heat soup and provide meals that way. The landlord discovered that the son was unable to care really adequately for his mother when he came to collect the rent. He called the Protective Services Program. Fear of separation from his mother, again, the son resented and fought the efforts to help. But he was amenable to the trusting relationship of the claim caseworker who carefully and very thoughtfully approached the situation. But the greatest resistance to providing help to this 84-year-old lady was the resistance of the hospital to accept her return back into the hospital. It was necessary for her to return to the hospital because there was no other alternative for her care in this community. The hospital said she needed custodial care and was not an acute care patient. They did finally admit her only after a social worker, a visiting nurse and an attorney accompanied her by ambulance to the hospital and threatened to call the newspapers. The neglect in this case was a combination of the inability of a family member to provide care and a lack of appropriate discharge planning from the hospital. The limitations set up for categories and levels of medical care do not meet the special needs of individual families in a time of crisis. Neglect. Lack of the unassuming generosity of older people can be the result of what had been a well functioning family.

Mrs. D. was 86 years old. Her situation was brought to the attention of our program by the director of the counselling agent who had received reports from neighbors that Mrs. D. had been seen wandering around the neighborhood in a confused state. This was during the winter. She was wearing her nightclothes and slipped on snow on the ground. On three occasions, she was observed walking up and down the street and seemed to be totally disoriented as to where she was going.

Mrs. D. had four sons. She owned a considerable amount of property in town. Two sons lived nearby and two lived out of state. The four brothers did not get along and could not come to any agreement about a plan for her care. The two that were most available undermined constantly each other’s efforts to help and accused each other of attempting to pilfer her estate. The social worker was able to get the brothers to accept a plan for a few hours—only a few hours—of home health aide services weekly. But Mrs. D. in actuality needed 24-hour a day care either at home where she could have afforded it or in a nursing home. She died six months later without the adequate services that she had needed.

Mrs. M. is 68 years old. She is widowed one year ago. She has three sons and one daughter. She is severely crippled with arthritis and has a heart condition. One of her sons was serving a sentence at Walpole Prison when her husband died. He is a heroin addict and when he was paroled, he moved into her apartment. He was angry that he had not been properly notified about the death of his father and blamed his mother for that. He was verbally abusive to her, stole money from her, stole a television from her and stole a stereo which her husband had bought on time and was his prized possession. She was referred by a visiting nurse after Mrs. M. was discharged from the hospital to accept her care. She had been seen wandering around the neighborhood in a confused state. She had been seen again. She was cleared of her release from the hospital. She was referred by a parole officer to get the son to move out. However, she could not bring herself to press charges against her son in any way to try to reclaim any of the property which he had taken from her. With the help of legal services, she was cleared of her responsibility for debts which he had incurred on her charge account. But it took two months of work with her to get her to deal with the embarrassment and feeling of shame that she had about the whole issue of indebtedness that he had incurred and her good name. She felt, was being tainted by not paying her bills.

The last one I wish to share with you is a case involving a woman named Miss C. who was 76 years old. Her only relatives are a nephew and his wife with whom she has almost no contact. She is a very passive and dependent person who has been this way all her life. She has lived alone for the past six years since the death of her sister, with whom she has lived for many, many years. She was referred by a visiting nurse on the basis of her own complaint to the visiting nurse that her conservator was stealing from her. Miss C. is unable to handle her financial affairs. She receives the vast amount of $335
per month in combined social security and supplemental security income. The conservator handles her bills and helps her with grocery and other shopping. The fee which this attorney, who is her conservator, charges for these services is $100 a month. This appears to be a somewhat usual charge, a minimal charge perhaps for such services. Assessment of Miss C’s complaints revealed that, indeed, her complaints of abuse are realistic. She is unhappy, however, to change her situation. She is frightened, she does not know who else will take care of these kinds of tasks. Indeed, until there is some form of resource such as a guardianship corporation, we have no alternative to be able to provide the kind of service which this attorney does provide, constant shopping, handling of the bills, paperwork, that kind of thing. This kind of abuse results when there are no other alternatives in the community and when the client is really dependent and fears any effort to move in the direction of being more independent.

I thank you for the opportunity of being able to share some of our observations about what we see as an increasingly troubled problem of abuse and neglect.

Mr. DRINAN. Thank you, Mr. Langdon. If I may, I have a couple of questions for you and then I have a couple of questions going back to Mrs. O’Malley’s testimony. Going through your cases, my mind keeps raising the question: What legal arrangement could have prevented this or helped it? Take, for instance, the case of the 86 year old woman with four sons who could not agree on a plan. What legal remedy could have helped?

Mr. LANGDON. Well, in that instance, I think, for an agency or somebody to have authority to even be able to get into a situation like this was fortunate in that we were able to get in because we were able to provide the counseling over enough period of time of the son who was the closest, living next door, to even let us into the house. He had thrown out a case manager from Elderly Services who had tried to go in. He had threatened legal action if anybody went through the door. So, first of all, I think there is the need to have the authority as with Protective Services for Children, that when there is an abuse or neglect situation reported, that somebody actually can investigate it.

Mr. DRINAN. Would you suggest that the Massachusetts law needs to be amended to permit entry into a home to investigate suspected abuse of an elderly person?

Mr. LANGDON. Yes, but with the caution that the rights of privacy of people, and the sanctity of the family be respected. Such a law, I think, would require highly skilled people on the staff who understand the dynamics of families and the issues of families.

Mr. DRINAN. But what other legal arrangement or legal amendment would you be suggesting as a result of your findings?

Mr. LANGDON. Certainly, the need for a Guardianship Corporation like the one in this state as a legal entity which can provide guardianship to low-income and indigent persons who need much of that kind of service and frequently need it more than those who are more affluent. If you are affluent you can secure the aid of proper persons to manage your affairs. Another legal change that we see certainly is the need for limited guardianship and conservatorship. In some of the cases which I did not use here, we have found that people often secure conservators or guardians during a period of stress or crisis, often when they go into a hospital, and, following discharge from the hospital. But people change, they grow, they get better and it’s very difficult unless you’re an extremely sophisticated person to change that legal status. People do not always need a guardian who takes care of all of the responsibilities in their life.

Mr. DRINAN. Do you have any particular proposals about alterations in federal regulations or federal law that would assist in some of these situations?

Mr. LANGDON. I think that in the federal law, perhaps, the most important thing is to support states in getting funding to help us to begin to develop programs. I certainly would support and encourage any efforts to allow us opportunity for demonstration projects and programs where we can do some of this pioneer work.

Mr. DRINAN. Well, one last question and perhaps Dr. Mahoney will have some questions, but my mind also raises the question whether this is neglect or whether this passes over the line and becomes abuse. In these instances, I would think this is neglect but are we prepared to say this is intentional abuse.

Mr. LANGDON. I see very little need to differentiate between abuse and neglect. I think as with children, neglect becomes abuse. Neglect is the first step to more serious physical abuse. In some instances, what is happening is people could be considered emotionally or psychologically abused. Our experience has been different than the research indicated in terms of physical abuse and battering. Now, I don’t know if it is because we have not been strictly a medical kind of program. We have seen, by far, abuse in terms of the kind of harassment that happens to people, and deprivation of entitlement. But, we have not seen the extensive kind of abuse that was cited in the recent project with bruises being one of the most primary symptoms.

Mr. DRINAN. Thank you, Mr. Langdon. Our next witness will be Meredith Savage, the Regional Ombudsman of the Connecticut Department on Aging.

STATEMENT OF MEREDITH SAVAGE, REGIONAL OMBUDSMAN, DEPARTMENT ON AGING, STATE OF CONNECTICUT

Ms. SAVAGE. Thank you. My name is Meredith Savage. I am the Regional Ombudsman for Eastern Connecticut. From the other cases I have heard today, we’re all pretty much running into the same type of problems. I would like to tell you that under Connecticut law we are required to investigate any complaint alleging abuse, neglect, exploitation or abandonment of any citizen age 60 or over. In my particular area, I am in East Sturbridge which is rather rural, I cover 66 towns. We have another piece of legislation to investigate the same kinds of complaints stemming from nursing homes. So, we have a pretty broad spectrum with which to deal with. Probably one of the most interesting cases, and I say interesting because it is about the worst case I think I have had, happened to be my first case. This happened February 1, 1978 and to compound my agony, Jackie Wilson,
my boss was out of town. But I want to relate it because another point I want to bring out is we use four categories and in many, many cases we cannot use just one. In other words, the case we are going to talk about involved physical abuse, neglect, and exploitation. We are finding this is more and more cases. What we hear from the family is that we love Mama and we will never put her in one of those nursing homes. But the translation is Mama owns the farm and if we put her in one of those nursing homes, there goes the money. I think that's something we should all be particularly aware of.

In this particular instance, our department of social services called me stating that a mentally retarded young man had told his social worker that his grandmother was being physically abused. This is all we had to go on and the worker and we don't know how good this information is. With that, I paid a call on the lady and took a legal services person with me because the social services in our state was not involved in the program so I got a legal assistance person to go.

We located the woman off in the country and said yes would you get in. Her daughter met us, there was nothing wrong with Mama and so forth and so on. Finally, we talked our way in. I said I was from the State Department, an agent and part of my job was to talk with an elderly person. The daughter's husband heard the word "state" and finally let us in.

I walked into what I think is one of the worst situations I have ever seen. It was basically a two room shack. There were no inside walls. There were just outside boards, no insulation, no sheet rock, nothing. There was a kitchen with a cold water tap. Then, a fairly large room contained an elderly woman, 86 years old, her daughter and son-in-law, the daughter's teenage children and my client's two mentally retarded grandchildren also. I located something in the vicinity of 20 to 25 cats and dogs. They, believe me, were everywhere. They were crawling in and out of the sink, on the food, back into the floor and so forth. There was a cold water tap. My elderly client was there. She was 86 years old. She was in a metal chair restrained by a chain. I got to talking to the daughter on the basis of why do you use that type of restraint? A nurse taught me, she said. If I use cloth she's going to rip it. Her mother also had black eyes that, I paid a call on the lady and took a legal services person to go. On the walls, and so forth. The son-in-law was well known to be violent. He is also known to be armed most of the time, and has been in prison for attempted murder. He threatened to murder the detective that was with me. On this particular day he was carrying a pair of scissors which made me nervous. We had heard there were dogs and were told she could be moved from there. She was totally incoherent. Her son-in-law said you cannot do that. He is the one who was abusing her. She was placed in the home as an elderly person. The daughter's husband heard the word "state" and finally let us in.

The upshot of this case is that two other agencies had been in that home. When we started breaking it down we learned that between the client, the mentally retarded child, and the dependent children, about $500 a month tax free money was going into this home, plus the son-in-law worked. In the end, the probate judge conserved the woman and we immediately got two doctors. The probate judge named the chief administrative officer of the town her conservator for 30 days. That gave us time to have the woman examined to see what her physical needs were. It was obvious she had to be placed in a nursing home which the conservator could order.

The couple was charged with cruelty, but I don't think they were ever prosecuted. The mentally retarded boy was placed in the home as were the minor children. The minor children were returned some two months later, I believe.

Again, that is one of the worst cases we have ever had. I think it certainly points out that we have a problem. I don't think any of us realize the enormity of it until we really started getting into it. What we're finding is that the more and more people who are aware of the protective services for the elderly, the more and more phone calls we're getting. We have a string of mandated reports very similar to that used for child abuse. Again, the more that the public becomes familiar, the more and more people call us in.

Another case that I think is extremely interesting involves a call I received about a woman left alone in this home in Waterville. I did a little digging and I found that she had been living with a companion for some 20 years. He had been struck by a car and was hospitalized. I paid a call on this lady and it became obvious that she couldn't help me at all. This woman knew nothing except her name, Dorothy. She did not know how old she was. She couldn't even read or write. When I went into the apartment, I could smell within 20 feet of the door it was really bad news. There were open cans of food all over the floor.
STATEMENT OF MEG HARARI, CAseworker, FAMILY Service
ASSOCIATION OF GREATER BOSTON, MASSACHUSETTS

Ms. Harari. Thank you. My name is Meg Harari, Unit Supervisor, Family Service Association of Greater Boston, Service for Older People. Our unit provides counseling, advocacy and outreach to frail elderly who, because of physical or mental handicaps, are not able to themselves to counseling and delineation of resources we can help an elderly client remain in his own home.

The majority of clients we see suffer from impaired judgment, poor physical and lack of knowledge about resources. A small percentage of our clients, about 1 percent, are particularly high risk situations. This is the most difficult kind of physically and emotionally dependent on the abuser, who as we've seen, occasionally a daughter and in a few instances, a husband or wife. The abuser tends to be an alcoholic, a drug addict or a person with a history of mental illness. The abuser rarely is receiving any kind of social service. A typical case is Mrs. X who is 76 years old, physically handicapped, using a walker.

Mrs. X and the place where an 80 year old grandson who has a history of drug addiction and alcoholism. He is separated from his wife and children whom he abused. Mrs. X was not bound by her grandson to steal all her money and food and walked out on her. She was referred to us by home care after a report from her homemaker was filed. Mrs. X was given additional homemaker service and financial help. Contact was made with her family and the name on her bank accounts were changed. A week later, the grandson called and Mrs. X welcomed him back, denying that he was anything but an exemplary grandson. It may take months to work out a better life for Mrs. X until she can accept a plan where she is assured the kind of care she needs without being so dependent on the grandson. The worker will also attempt to involve the grandson in counseling and set up liens against his mal-treatment of his grandmother.

In cases where the elderly person does not complain, the presence of the worker cannot be deterrent against further abuse. Working with this kind of situation requires long-term involvement. Abuse tends to be the product of social isolation, lack of treatment for mental illness, addictive conditions and disturbed family functions. We do not find abuse among elderly in housing projects or elderly who are an integral part of the standard family system.

Another example that illustrates these points is Mrs. A., age 76. The abuser was her husband who was 70 years old. They married when she was 60. Her health declined and she gradually became senile. Mr. A. worked all day as a cook and left his wife alone in a tiny basement room crawling with insects although with their combined income they could have afforded a good housing situation. Left alone without adequate food or supervision, she had frequent accidents with multiple fractures and was repeatedly hospitalized. She was placed in the nursing home but moved against medical advice by her husband. There was no family or friends. Mr. A. had a gun and was threatening everyone who would keep his wife from him. A family service worker worked extensively with Mr. A. about alternatives in caring for his wife. Better housing was offered. However, Mr. A. wasn't cooperative. When Mrs. A. was later hospitalized, Mr. A. again wanted her back home. The hospital finally instituted temporary guardianship and later permanent guardianship procedures. Mr. A. was brought to court and our witness testified about the home situation. The court ruled that the hospital could assume guardianship and that Mrs. A. be placed in a nursing home. She has since done very well and appears more mentally alert.

One of the major difficulties we found in working with the abused elderly is the lack of resources in a non-protective living environment. Mrs. K., a 75 year old widow lived with her 42 year old son who was diagnosed as schizophrenic. He threatened her and all the neighbors with bodily harm. Mrs. K. felt shame as a result of his public behavior. Mrs. K. developed very high blood pressure, was not only afraid of what would happen to him if she left but of what would happen to herself if she stayed. She went through the courts which kept her son...
At first the son was accepted in senior housing as protection from her son's abuse. At first the son was barred from visiting Mrs. K. But finally, he learned to behave and comes to see his mother peacefully. He is now receiving services at a mental health clinic. Mrs. K. sees the social worker for counseling and emotional support.

There are numerous questions about elderly abuse. Tragically, we find that the situations where we intervene have been rare. Systematically, the elderly abuse tends to be systematic with general lack of social services for the elderly. We feel that a concerted effort in this direction is an integral step in reducing abuse. But, with additional social resources, abuse can be uncovered soon and more elderly protected. Thank you.

Dr. Mahoney. Thank you very much, Ms. Harari. May I just question this. You and others have suggested that this is just the tip of the iceberg and I'm not certain that the evidence supports that. Other people suggest that senior elder abuse may be increasing and I don't see evidence to support that. Would you talk about that point?

Ms. Harari. Well, the incidents appear low. About one percent of our clientele have been abused as such. But we are concerned that we are only seeing the tip of the iceberg as someone put it before. With more publicity, we may uncover more cases, many more cases. But we are concerned that those who are elderly, whether mental or physical, is a life threatening situation. We feel that through proper social service intervention, lives can be saved. Lastly, we feel that intervention for the abuser can rehabilitate him at the same time.

Dr. Mahoney. But, would you agree that as far as I read the survey and other information such as it is and it's in very, very short supply, that we shouldn't generalize and say that it's increasing or it's much more widespread than we know!

Ms. Harari. According to the cases in our agency, this is something that's been occurring in recent years.

Dr. Mahoney. Well, if I heard you correctly, you said that you didn't have any record of abuse in housing projects. I think, goes to say against that. Certainly, in urban housing projects, there have been gangs terrorizing elderly, snatching handbags from elderly people, inflicting violence on them and this has been going on for a few years.

Ms. Harari. In our survey, we found that in their housing projects with safe supervision and good locks on the doors, there hasn't been any.

Mr. Brennan. If I may interject here, the House Select Committee on Aging has held hearings on crime against the elderly and it is very, very shocking that there are, as Dr. Mahoney says, gangs. That is a separate problem, however. We are not talking about that. That is not neglect or abuse of the elderly. That is just old-fashioned crime against the elderly.

We thank you very much, for your presentation. We move now to a new panel, issues in treating cases of elderly abuse. The first witness is Mr. Howard Segars who is a psychologist for Legal Research and Services for the Elderly.

STATEMENT OF HOWARD SEGARS, PSYCHOLOGIST, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LRES)

Mr. Segars. Thank you. My name is Howard Segars. I am the staff psychologist with Legal Research and Services for Elderly. I've worked with the abuse project since it began in February of this year. As part of that job, I helped with development of the state-wide survey project sites in Massachusetts. As part of the preparation for those abuse against spouses, domestic violence against children as well as the abuse directed against those elderly people. In addition to that, I spent some time talking with a variety of professionals, people in ministry, people in social work, people in medicine and nursing, about their experiences.

Before I came to this job, I too, worked in a protective services unit and one which had somewhat different case load than that of Ms. Harari. My staff and I worked in poor city neighborhoods, exclusively hundreds of people while I think, by and large, are really dedicated, sincere individuals. I've seen sometimes staggering sums of money allocated in the community and yet I cannot say that I've seen a great deal of change taking place in that elderly abuse. Whether mental or physical, is a life threatening situation. We feel that through proper social service intervention, lives can be saved. Lastly, we feel that intervention for the abuser can rehabilitate him at the same time.

Personally, I have regarded the horror story testimony with some suspicion. But I am equally wary of the sort of theorizing which gets detached from what all of us experience on a day to day basis. I am hopeful that people will not get lost, that people will not get lost, that testimony today will have something to do with framing some more adequate, realistic responses that will truly address these theories.
I've often had to suppress my tendency to talk about the devastating impact of this case. When you're treating it as if it is some self-contained unit; when you're considering it from a professional critical point of view and it is counterproductive from a management point of view. If we content ourselves for a moment with an emergency response, let us consider that there may be a problem of housing for this client while she tries to make up her mind about what to do next. Emergency shelters have time limits. Psychiatric brothers don't. Emergency shelters rarely have provisions for those who suffer from the indignities associated with aging. Nursing homes do. All too often it is small wonder that those who need help are reluctant to avail themselves of it. Old people are by and large just that; they are old. Almost 90 per cent of those victims reported that they were not stupid. Almost 90 per cent of those victims reported that they knew the likelihood of options open to them. They refused services because the services were limited and they were perceived as threatening as the conditions the clients were already experiencing.

Emergency cases, such as the one I have described, generally fall into the more restrictive category of programming. For all the discussion and for all the writing about least restrictive alternatives (which has become a buzzword in my profession and many others) the whole thing is academic if those least restrictive alternatives don't exist. You can talk about them, you can write about them, you can develop different kinds of abuse response models which utilize them, but if there isn't money to pay for them, who really cares? That is why there are emergencies. There aren't the alternatives that are supposed to exist. On the other hand, and I hope the more fortunate one, it's good to look at a case that was programmed non-emergency and I think prevented nursing home placement through good case management.

In this case, the client was an immigrant woman in her late 70's who had enjoyed a pretty active life until visual problems and a few other minor infirmities made it difficult for her to live alone; not impossible, but difficult. At that point, she accepted a middle-aged niece's invitation to live with her and share expenses. The niece, it soon became apparent, however, was a troubled person who was really unable to provide many, if any of the services she had offered. The caretaker/niece began not only to cash but to misappropriate her aunt's checks. Worse, she locked up all the food in the house and starved the woman as well. The story emerged in a curious way. First, the client told a friend who herself was elderly. That person participated in a recreation center through a Title VII nutrition program. She told the recreation worker. The recreation worker in the Title VII nutrition site in turn told a protective services worker who brought it to my attention because I was administrator of the grant. The aunt had reason, I think, to use that kind of round-about way of asking for help.

On one occasion her niece had begun deportation proceedings against her and she constantly threatened her aunt with nursing home placement. The worker assigned could have investigated the case and simply offered the same nursing home option as the niece, treating the case as an emergency and not as part of a possible longer term solution. Instead, she realized her client's desire to remain outside an institution, a desire so strong that the aunt was willing to risk staying in an almost certainly abusive situation rather than accepting temporary placement in a nursing home which generally means long term, if not life-time placement. While the elderly woman stayed with her niece for another two months, the protective service worker was able to maintain counseling while referring the niece—who repeatedly refused ever to discuss these issues—to Social Security for an investigation of the alleged misappropriation.

Social Security was very useful there. This allowed the client to regain control of her funds, something which she had always been able to do but this was something that the niece had simply taken away from her. Once the client had an income, no matter how limited it was, it was possible for the worker to begin looking for suitable living arrangements. At that time, the Commonwealth had enough money in this region to offer some extended services so the minimal services which had previously been offered by the niece could be covered. Her new living arrangement was near a Title VII nutrition site so she had food and companionship regardless if she chose to avail herself of those services. I maintain that if this case had been treated as an emergency, if the client had only been offered a nursing home placement instead of some less restrictive alternative, if there had not been money for housing extended services which made the move into independent housing possible, she wouldn't be alive today. Either the effects of slow starvation or the physical effects of the niece or involuntary institutionalization would ultimately have proved lethal. I am concerned that we not forget that people die through programmatic failures. The Rose Institute Study shows conclusively that for people who experience involuntary institutionalization, 20-40% of
them are dead within 6 months. Now, there are a lot of ways to look at those statistics and I hope we do not get into a debate of what they mean. It does indicate, however, whether 20% or 25%, some people are dead as a result of this manipulation and that I find reprehensible.

For me, these are only two of a much larger body of cases which I personally have witnessed. I have repeatedly seen middle aged children threatening their parents with nursing home placement, for whatever reason, whether it is to gain control of resources or simply to relieve themselves of the tedious task of care. I have seen people overmedicated because physicians have said, "when your mother starts to act up, give her two more of these." If two are good, four more are better and six more is best. These are daily occurrences for all of us who have worked in the field. There is no need for this. All of us are going to get old. Many of us are going to find exactly the same things happening in our own families. Ignoring this kind of problem will hurt us all. I truly hope that because of this testimony today, the work that we do tomorrow, we are going to be able to begin making some changes. They do not have to be that costly. But they do have to be coordinated. Thank you.

Mr. DIWAN. Thank you very much. If I may, may I suggest that you spell out the changes that you are calling for—first at the federal level. Would you have any specifics that you would recommend the Congress follow?

Mr. SEGARR. I would like to see, as Jim Bergman pointed out this morning, some incentive given through Title XX perhaps, not only to develop different kinds of services but to reward those states and those communities which coordinate services. I, for example, administered a half million dollar adult protective services grant which was paralyzing through the Department of Public Welfare, but which depended for most of its support services on the Department of Elder Affairs. There's no linkage between those two, and of course I was able to get that money to help people sit down occasionally and say there are x number of cases here, there are x number of dollars there, you do this and this and this. We'll do these other things.

Mr. DIWAN. Would you suggest anything that could be done about emergency shelters?

Mr. SEGARR. I think that there should be emergency shelters. But I think first we have got to track some cases and set up a system which will allow that to happen. Once you have got that base to work from, you can figure out where the centers should be located. I have got a lot of people beyond the point where I have to be convinced that shelters need to exist. Personally, I already believe that. I am not certain where they have to exist. I don't know what they should look like, and I don't know how they should be staffed. I do know that there are people available on the Department of Elder Affairs staff and in private agencies who can answer those questions. I think that you could use computers to track cases if you have got a reporting law and find out in a relatively short period of time how to develop shelters and how to do it in a way that is responsible.

Mr. DIWAN. Would you say there is a consensus among all the knowledgeable people in this area that we should have emergency shelters?

Mr. SEGARR. I think not only for elderly people but for disabled people, for people who are being returned to the community.

Mr. DIWAN. Well that is another but this is a new dimension.

Mr. SEGARR. Certainly, without question.

STATEMENT OF RUSSE MORAN, DIRECTOR, ELDER SERVICES OF MERRIMACK VALLEY, INC., MASS.

Mr. MORGAN. Thank you, Congressman, Dr. Mahoney, ladies and gentlemen. My name is Russ Moran, I am Executive Director of Elder Services in Merrimack Valley and I would like to thank you for the opportunity to address this critical problem affecting all the people who have been abused and neglected.

The problem is real and needs immediate attention. With the increasing number of older people and the increasing pressures, tensions and frustrations of today's society, the older person becomes an extremely vulnerable target. I would like to limit my response to some of the concerns that have become evident since the protective service program began in the Merrimack Valley about 12 months ago.

The services are delivered by a consortium of three family service agencies acting to provide intervention and support. Approximately 25 percent of all the referrals to the program are made because of the extensive abuse by a family member or other person. Most often, the abuse appears to have developed over many years and often family members see a need for this kind of action. The program then confronts two problems. One is resolving the immediate crisis or problem and the other is attempting to begin to work with the family over a long term basis. Neither is easy and often can be impossible.

As in child abuse, the older person is not always willing to recognize the problem because of fear of retribution or loss of security. Adult children or grandchildren are often themselves unable to see the problem and can be unwilling to accept community support. How the community responds, then, is critical. Police departments, emergency rooms, and mental health agencies must become aware first that the problem exists and then that something must be done together.

I again stress, as was stated by the previous speaker, the aspect of coordination. Services must be coordinated and delivered in a manner that does not jeopardize the outcome of the plan of care. Once the immediate crisis is stabilized, long term support should be available to minimize the possibility of future problems. Such long term support can include counselling, specialized homemaker services and case management as well as informal support and I would stress informal support. Networks can be developed and can be made to be responsible, progress can be made despite barriers that exist.

I believe, however, that we are in reality providing a mandated approach. There is clearly a need for protective services. We must begin, however, to move in the direction of intervention. We must know why the problem exists and what can be done to ensure that abuse of the elderly will be reduced and hopefully eliminated. Currently, the system of service delivery that we all operate under often encourages the problems that are being discussed here today. Because of inadequate funding, support services were only delivered to those
elders in greatest need. This is true of Medicaid, Title XX and Title III funds. While this program is clearly necessary, it inappropriately assumes that old people are being served to the full extent of their needs. What happens, however, in reality, is that we only serve those in the most desperate situations. This encourages poor people to become poorer and sicker before they receive services. In addition, since our focus is largely on locating isolated, elderly people, we often forget the outreach that must be done in families.

An article on aging and family by Elaine Brody at the Philadelphia Geriatric Center disputes the belief that many families are abandoning their parents. She states "the myth may express the guilt of a youth-oriented society in need of a scapegoat for the general neglect of the old." If anything, the informal support systems of the family, friends and volunteers provide a wide range of care, but unfortunately, however, this informal support system often jeopardizes the delivery of formal supports. In a system that serves only the most desperate, social services are often terminated or not made available to people if there is family involvement or other informal support. This may be done because there is a choice of offering care to one who has no involvement or to an older person who does have family involvement. So again we continue to insure that older people will have to deteriorate further before we caregivers can help. The family who is blamed for abandoning their parents, but was actually involved in providing care could not get the support from the community, becomes resentful and frustrated. The stage is set and the old person is a visible and vulnerable target in the system.

Obviously, there are other causes that may affect older abuse. Families must have access to community agents. Policy makers and providers have to begin looking at treating the entire family unit rather than just individual, isolated members. Categorical funding has to allow for some discretion in eligibility requirements. Funding levels have to be made realistic and cannot be used to create a future demand for services. In general, we must not only treat the symptom, but must treat the underlying problems that create the symptoms. I believe to succeed in this will take commitment at all levels of government.

Protective services have been discussed for years and as an example, here in Massachusetts, protective service has been listed as part of the Title III state plan for elderly people for the past three years but has never been funded. This year they finally recognized that and removed it from the Title XX plan rather than put money into it. This is disturbing. The commitment must be made now because delay only jeopardizes the health and safety of many older people. It is time to stop talking and start doing. I respectfully ask for the full support of Congress and the state, and you can depend on our support. I would like to respond to one question you asked earlier, that is whether we can demonstrate today whether there's an increased need. I am not sure we can demonstrate it today because we have not been given the resources to demonstrate that. The resources, as indicated earlier, have largely been patchwork. I think what Mr. Bergman mentioned earlier, research and demonstration grants have to be made available to truly demonstrate the magnitude of the problem and what are some of the causes. I think those are some of the things we can relate to you and

we look forward to working with you and other members of the state and federal government.

Mr. DRINAN. Well, thank you very much. May I ask this question which has not been brought up today. Is there a role for volunteers or community groups in this area?

Mr. MORAN. Yes, I think a very critical role they can play, in meeting needs that were refused by formal support systems because of eligibility requirements or other barriers to service. They can provide long term support and have outreach into the community. This can be done by protective services and other support groups. This is critical and has to be made part of this network. If I may relate an organization in my own congressional district in the Pittsburgh area, they monitor nursing homes and on a voluntary basis, they have done really extraordinary work. They are in the business of looking for a federal or state representative to support them in this care. We can have a part time or full time executive director who will just keep the correspondence and that type of thing.

Mr. DURAN. Would you see a need in the area of neglect or abuse of the elderly for such an organization?

Mr. MORAN. Definitely. To help professional caregivers who because of limited case loads or decreased funding can only rely on the informal support of volunteers and family members and churches to play a very significant role in at least maintaining stability on a long term basis in a family situation and can help us monitor that situation as well.

Mr. DRINAN. I was wondering where, since it has taken so long to discover child abuse and spouse abuse, do you think we are going to have to span the same number of years before we really get a good handle on this problem?

Mr. MORAN. I hope not. I hope we would have learned some things from child abuse and spouse abuse, I think we have to be careful when we say we were discovering elder abuse. I do not want anyone to assume that this is just becoming a problem. The problem has existed, it is just that we did not know it before.

Mr. DURAN. Thank you very much. Now the next witness is Jacqueline Walker. She is the State Nursing Home Ombudsman for the State of Connecticut.

STATEMENT OF JACQUELINE WALKER, STATE NURSING HOME OMBUDSMAN, DEPARTMENT ON AGING, STATE OF CONNECTICUT

Mr. WALKER. My name is Jacqueline Walker, I am the State Nursing Home Ombudsman with Connecticut's Department on Aging. I am here to testify on Connecticut's experience with abuse and neglect of the elderly. In July, 1977, Connecticut passed two important pieces of legislation dealing with the elderly. One bill was the establishment of the nursing home office, an office within the Department on Aging. The other was a reporting law for the protection of the elderly. That has to do with any person sixty years old or older, anywhere in the state, institutionalized or otherwise. It is concerning this bill that I wish to testify.

At the time this piece of legislation was introduced to the legislature for passage, the Department on Aging was unable to uncover any
definitive statistics concerning the number of elderly persons who had been abused or neglected in this state. We made inquiries at hospitals, emergency rooms, police and family service agencies, but none of them produce statistical information. Fortunately, however, the legislature passed both the house and the senate with no problem.

This success was due in part to the effort put forth by Representative William Ratchford, former Commissioner on Aging and Chairman of the Governor's Blue Ribbon Committee To Investigate the Nursing Home Industry in Connecticut. The office is funded with $250,000 which covers the salary of the staff as well as the operating expenses of the ombudsmen. The staff is comprised of a state owned ombudsman and five regional ombudsmen who work out of the five home planning and service areas of the state.

The ombudsmen are responsible for receiving and resolving nursing home complaints and problems presented to them by family, friends, patients and nursing home administrators and which concern the life-style and care of the patients in nursing homes, rest homes and homes for the aged. The program went into effect upon passage of the legislation July 1, 1977. The protective services program went into effect the following January of 1978 and I would, before I go on, just like to interject that between January, 1978 and June, we really downplayed the program for the simple reason that we were waiting for the regulations to be passed. We did not want to go ahead without the regulations so that the number of cases that were produced between January and June are negligible.

It was from June even though the statistics I will read you later will view the entire period. That program utilizes two state agencies and functions in the following manner. Mandatory reporters consisting of primarily professional people such as nurses, physicians, police, social workers, ministers, etc. are required to report suspected or known cases of abuse, neglect, abandonment and/or exploitation of persons sixty years of age and older to the office. They may report the case either to the state or to one of the five regional offices. After receiving the report, the ombudsmen is required to make an immediate investigation and assessment of the problem. This requires a personal interview with the client as well as contact with as many involved agencies and family members as are available.

One the decision has been made by the ombudsmen that indeed there is evidence of neglect, abuse, etc. he discusses the problem and possible solution with the client. He suggests a course of action, including types of protective services which would benefit the client in his or her present circumstances. If the client agrees to this assistance, the ombudsmen then refers the problem to the elderly protective service unit within the department of human resources. The human resources is the new re-organization and it is social service or welfare but in our state they have now really messed it up. Each district office of the state department of human resources has within it a special unit called the elderly protective service unit. This unit consists of a supervisor, as well as at least one worker assigned specifically to that program.

On receipt of referral from the ombudsmen, protective services visits the client, works up the case and makes provisions for those services to be provided. The type of services may include such things as homemaker, home health aide, public health nurse, hospitilization, conservatorship, financial assistance, counseling and protection who evaluation. In those cases where a client refuses all the services which are offered, it is up to the ombudsmen to make a determination as to the competency of the client.

Because the ombudsmen spends a fair amount of time with each client, she, therefore, has the opportunity of utilizing such things as the mental status quotients as well as other methods of testing in order to ascertain whether or not in the ombudsmen's judgment, the patient is capable of making decisions. If, in the judgment of the ombudsmen, the client appears to be incompetent and thus is incapable of making a decision, the ombudsmen than refers the case to the protective services worker and writes those findings along with the report. When the protective service worker follows up on the case, he/she will in turn make an additional judgment as to the competency of the client before any services at the patients hand.

It is important to remember that the purpose of the program is not to interfere with the right of self determination of a person. Rather, it tries to provide services for a person who is in a dire situation and who can benefit from some type of intervention. Frequently the ombudsmen and/or the protective services person are able to obtain a psychiatric evaluation of that client. There have been some instances where a client is fully competent and is suffering from a terminal disease, realizes that her/his only a few months to live and simply does not want any help.

In instances such as these, we do not interfere. We allow those persons to make their own decisions and live and die as they choose. Our program has also developed a close relationship with the probate court system in Connecticut. At the time this program went into effect, another important piece of legislation was passed, namely an act concerning the appointment of conservators. The ombudsmen as well as the protective service workers met with the probate judges in every town in Connecticut to discuss the responsibility which would be put on the probate judges with the onset of this bill.

This bill provides for the appointment of emergency or technical conservators, for those individuals requiring immediate attention. There have been many instances where we have used that vehicle. In some cases, the situations have involved immediate hospitalization or delivery of services to the person in order for the person to survive for a few days until medical attention could be obtained. Since the program has been in effect, there has been an overload of cases reported to our office. More cases than we ever anticipated and more serious than we ever anticipated. The ombudsmen have been astounded, sickened and shocked to see the severity of problems in situations which abound in the community. Problems which, until this time, have been unnoticed by agencies and community officials.

The period from January 1978 through April, 1979, the total number of reported cases is 857 with a total number of problems associated with those cases 1,085. Of these reported problems, there have been 651 concerning neglect. Neglect includes both self-neglect, those elderly who have become incompetent to the extent that they were incapable of
providing basic, necessary care for themselves as well as neglect by a caretaker. The caretaker being either a family member or the conservator or another person residing in the same home.

There have been 161 cases of physical abuse. From our statistics, a majority of abuse has been inflicted by either the grown children of the abusee or by a spouse. In spouse abuse, it has been primarily the majority of abuse has been inflicted by either the grown children of the abusee or by a spouse. In spouse abuse, it has been primarily the

As I indicated before, the ombudsmen have been astounded at the severity of the cases that have been running rampant in the community. Of the 169 towns in Connecticut, 107 have reported cases to date. All mandatory reports received packets with a brochure outlining their responsibility as well as the report forms. In addition, meetings have been held and are continuing to be held with social services agencies, hospitals, local and state police and citizens to more fully discuss the program and its implications.

In order to more fully emphasize the workings of the program and the types of cases that we receive, I would like to relate to you a few examples of cases which were taken from our files during the past year. Mr. and Mrs. A. live in an apartment over a store. The son, age 22, lives with them. They are the only tenants in the building. The son has been physically abusing the parents for many years. Usually following arguments over money. The son demands money and when his father refuses, the son beats him. The last incident was in March, 1979 between 10:00 p.m. and midnight. The mother was struck in the back with a frying pan and the father was clubbed with a stick. According to the parents, the son has a problem with alcohol. He is a physical addict. He has had psychiatric help in the past. The parents have had to have him arrested only to be released by the police. The son told the parent that if they sent him to Connecticut Psychiatric Hospital, that he would kill them when he got out. The son refuses to leave the apartment and the parents are terrified. They refuse to return to the apartment.

The father is a cardiac patient and a diabetic. He suffered a heart attack after the last incident of abuse. The recommendations by the ombudsmen were the son should not be allowed to remain in the community and that he needed psychiatric evaluation and possible placement in the state mental hospital. The parents feel he needs lifelong placement in a mental hospital. The parents will require a protective environment as well as counselling while arrangements for the son's care are being made.

Two people arrived at the VA Hospital because of what had happened to them. The VA physician called the ombudsmen who arrived on the scene where this history was taken. The result of this case was that the son had a psychiatric condition and was admitted to Connecticut Valley Hospital. There is some question as to what will happen if and when the son gets out. However, when a protective service unit took over the responsibility of this case, they agreed to follow this person for the entire time he is in the hospital. When and if the son is discharged from either a facility in the hospital, they will receive a notice of his discharge and can then make the appropriate arrangements for protection of the parents.

I am going to skip next case just to shorten this up and give you perhaps just the last one. This case concerns a woman who lives alone in a huge, decayed old house. She lived there with her father until he died three years ago. The woman is obese with a lymphatic disease. Her left leg is extended to the point of elephantiasis. Below her knee where the infected condition existed, her foot is an inhuman looking mass of pustules. At one point the flesh had eroded away and the bone is exposed. This person denies any problem with her leg. She wraps saran wrap around it to shrink it. The odor in the house is a putrid stench that permeates the clothes of anyone that enters the house. When her father died, a conservator was appointed since a great deal of money and property was left to her.

The conservator is a cousin who has very little to do with the client other than to pay her bills. The client is fairly lucid in most conversations, however, there are times when she seems to appear to be extremely confused. She has food delivered but has no working refrigerator. She uses only three rooms of the house and sleeps on a filthy, dirty, torn, stained couch. Her clothes are covered with blood and drainage from her foot. She refused any help but absolutely needed medical attention.

After referring this case to the protective services worker, the woman was finally taken to the hospital after the necessary action to accomplish this was taken care of by an order from a probate judge. She is now calm and cooperative and is receiving treatment at a hospital. There will possibly be a biopsy and subsequent amputation of her leg. She also has a large mass in her stomach and has been diagnosed by a psychiatrist as a schizophrenic. It is hopeful that when this client is finally released from the hospital that she will be able to go home to her home with proper assistance in terms of a homemaker, home health aide and certainly, a visiting nurse at least initially to assist her so that she can live a relatively normal life.

I have attempted to relate some cases which we consider to be typical of the problems received in our program every day. A day does not go by in which each of the regional ombudsmen does not receive at least three reports of some kind concerning neglect, abuse or exploitation.

The program is time consuming and keeps the ombudsmen constantly on the go, especially when added to the nursing home problems which continue to come in as usual. We realize fully that as the program continues and as more and more people become cognizant of our work, we will be inundated with problems.

There is no question in our mind as to the importance of the program. We realize fully that there are endless numbers which are still hidden away, waiting to be uncovered. From our brief experience, we can readily say that abuse and neglect are prevalent in all walks of life. There are equally as many problems in affluent neighborhoods as there are in poverty stricken areas, in rural as well as urban areas. The problems are found in all ethnic groups. Women over 75 were more frequently reported than any other age. This year, the ombudsmen
office anticipates that it will be able to do some research and analyze elderly injuries in order to document those injuries which can only be attributed to mistreatment and abuse rather than to accidents. This has been done for child abuse now so that there are definite criteria for children that can no longer be attributed to accidents on the child's part but can definitely be attributed to abuse by parents. We are hoping, I am not sure we will come up with anything because we are dealing with a much different age group here, that maybe we will be able to come up with this kind of information.

In addition, we hope to investigate and analyze the abuse as well as the conditions which may encourage and invite abuse, such as in the abuser a former abused child? Does the abuse occur more often when the older person lives in the grown child's apartment or home? Or does it occur more often when the children live in the parent's home? This kind of thing I hope we will get some information on. As yet, we have only touched the surface of the problem. Time will tell what the future holds for those of us who work with this type of program as well as for those of us who live to become one of the fortunate few.

Mr. DRINAN. Thank you very much. The next witness is Karen Meyers. I am a staff attorney on the Elderly Abuse Project of Legal Research and Services for the Elderly.

STATEMENT OF KAREN J. MEYERS, ATTORNEY, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LSSE)

Madam Chairwoman, my name is Karen Meyers. I am a staff attorney on the Elderly Abuse Project of Legal Research and Services for the Elderly. Over the past several months, I have conducted extensive research in the area of elderly abuse, focusing on the state of the law in Massachusetts, as well as nationwide. I have also conducted training sessions on this issue for social and legal service workers.

It is clear that any case of abuse is inextricably bound to the legal system. This is true whether one is looking at federal legislation, Title XX or state programs developed pursuant to welfare regulations, or, more specifically, when considering the remedies and procedures available to a client seeking service or to an agency seeking to provide involuntary services. Any case plan that is developed must be developed from a perspective that takes into consideration statutory and judicial alternatives.

Underlying these processes are the basic and fundamental issues of the civil rights and liberties of the individual. What stands out clearly
in this consideration of the law is that the existing statutes and remedies are by and large inadequate: although predicated on the importance of utilizing the least restrictive alternative in treatment and placement, there is insufficient funding and development of programs and alternatives which would make this premise possible. For example, legal remedies and intervention procedures do not always include service provisions which provide protection of the physical welfare and constitutional rights of the individual. There is too frequently reliance on inappropriate intervention procedures and consequently, violation of constitutional standards because of our so-called desire to do what is "best" for the infirm elderly person and because of our justifiable horror and discomfort with the reality of abuse.

Potential abuse clients can be divided into two initial groups. The first are those individuals who are willing and eager to pursue, on their own initiative, a legal remedy or service provision. Secondly, there are individuals who cannot or do not seek assistance and enter the system through intervention procedures. In the first case, the abuse victim can seek recourse through civil and criminal remedies. But the civil process does not necessarily provide a viable alternative. Most likely, the elderly person is dependent, emotionally or socially, on the abuse/caretaker. In these cases, the elderly person would never consider filing a criminal complaint because he or she might not desire to. This alternative also fails to provide protection of a victim. The criminal process operates in isolation from any service provision. These services are the basic support systems essential to insure the welfare or potential self-sufficiency of the individual.

Recent legislation has been passed in 24 states which establishes civil remedies and injunctive relief for victims of domestic physical abuse. Of these states, 17 have laws which include broad coverage provisions including the elderly person living with a relative or non-relative caretaker. Although the provisions of the statutes vary from jurisdiction to jurisdiction, the majority include protective orders, temporary restraining orders and vacate orders. The Massachusetts law, which I consider to be one of the best provides and to assure the safety of the abused person without requiring that person return to court once the order has been violated.

This legislation can be a useful and potentially effective legal tool of protection. However, its usefulness is seriously limited in the case of the elderly. The elderly person is often unwilling, because of fear, intimidation or sickness, to file a complaint. The fact that reported cases are not coupled with provision of supportive or protective services, or, if services are provided, they are not geared to the elderly, is another deterrent since the elderly person is often faced with the alternative of being left alone if the caretaker/abuse is removed from the home. Another limitation is that courts or police have been slow and reluctant to apply this law to the elderly. The elderly person is often unable to assert his or her own rights if the order is violated. The need to return to court, repeatedly, in order to enforce a protective order can be unduly prohibitive in such a case. Nonetheless, these statutes do provide alternatives for some elderly persons.

One example of this is found in the case that was related by Mr. Bergman this morning, where the woman agreed to seek a temporary order as well as a vacate order after four months of social service intervention. It is important to note that this took place in an area where BLS had an extensive protective service program in place. That program was able to provide the services which enabled that woman to go to court, take that risk, and be assured that she would have service provision after she was alleviated of the abuse/caretaker. In that situation the woman has been able to continue to live in the community.

Let me now turn to the more complex and difficult issues. As has been stated today, the elderly victim, who has been abused, exploited, neglected or abandoned is often in a vulnerable and dependent state. These individuals usually lack the physical or mental capacity or ability to seek or consent to assistance. States can act pursuant to legislative authorizations of Social Welfare, Public Health, Mental Health departments, and police procedures. But, the scope of this authorization is not broad enough. Social service workers repeatedly raise the question of their rights to initiate investigations, to intervene in family matters and to seek court intervention. These issues raise the classic conflict between the individual's right to privacy and self-determination in opposition to the power of the state to intervene in cases where state interest in protecting the vulnerable person arises.

I would venture to speculate that a majority of those persons involved in this area of law and social services would agree that there are those cases which do require intervention by the state and we could probably agree that services should be provided to persons-in-need who are unable to consent to the provision of such services. But, let me speculate that there exists a great disparity among these individuals when asked to consider what procedures and safeguards should be followed before the provision of involuntary services. Furthermore, disagreement would probably exist as to when such procedures and safeguards should be provided and what kind of services should be provided.

Individuals' rights to self-determination and privacy are not absolute. The state can certainly regulate the parameters of those rights through the police power and parens patriae. But, in addressing these issues today, we cannot forget that basic to our legal system is the right and sanctity of the individual to have free choice and self-determination. This right extends to the elderly no less than to any other person in our society.

Attempts by different jurisdictions to meet the needs of the elderly have resulted in the adoption of abuse reporting and protective services laws. Presently, 11 states have laws which provide mandatory reporting of suspected cases of abuse, neglect or exploitation, access pursuant to court order to investigate reports and provide services, and provisions for involuntary intervention and service provisions in certain cases. The majority of these statutes do cover adults who are either the elderly, 60 and older, or specifically people who lack the ability to obtain services for themselves for disability reasons or whatever. Five states in addition have established statutorily mandated voluntary protective services. These states do not include the reporting provision or the intervention provision. An additional 2 states have
adopted protective service legislation which includes involuntary service provisions but does not include mandatory reporting or investigation.

Of the laws that include involuntary services, a majority of them include provisions for hearings, assistance of counsel, the right to be present, and notice. But, shockingly enough, in these cases, where the issue is the deprivation of basic civil rights, there are 7 states which do not provide for due process of law. Persons deemed to be in need can be taken into custody and placed in a facility against their will “for their own protection,” without a hearing, without counsel, and without adequate notice. In order to resolve this conflict between the state’s interests and the individual’s rights, without losing sight of either, legislation should minimally include the following provisions:

(1) The adherence to the principle of less restrictive alternative and self-determination.

(2) A mandatory reporting statute which is linked with investigatory and service provisions.

(3) Prompt response of verification and assessment by the designated agency.

(4) Injunctive relief where caretaker intervenes in the investigation or provision of services.

(5) The right of the person who is deemed mentally capable to refuse services at will.

(6) Funding and development of least restrictive alternatives that make that premise a reality.

(7) Utilization of multi-disciplinary geriatric/clinical assessment teams in the provisions of services.

(8) Due process of law provisions including a hearing, adequate notice, right to be present at the hearing, the right to cross-examine parties represented and assistance of counsel prior to the hearing.

(9) Provisions for limited intervention, particularly in emergency cases.

(10) Provisions which enable flexible criteria to be used in order to reach all elderly persons in need and not just the very poor. And in all cases, the drafting and adopting of adult protective service provisions must be linked to the development of extensive service systems which emphasize alternatives to institutional care. Thank you.

Mr. DRINAN. Thank you very much, that’s excellent testimony. May I ask just a couple of questions. Of the 11 states that have laws that require mandatory reporting, is Massachusetts one of them?

Ms. MEYERS. No.

Mr. DRINAN. Yet, the Massachusetts law is, as you suggested, that a good law?

Ms. MEYERS. The Massachusetts law is good in terms of the abuse prevention law, that is, completely distinct from adult protective services or reporting. That is a law that requires to a victim of abuse to utilize the court system themselves, it does not allow for any sort of intervention or outreach. It is a civil remedy for abuse victims to get injunctive relief.

Mr. DRINAN. Well, in what other respects is the Massachusetts law deficient?

Ms. MEYERS. It doesn’t have any legal provisions in Massachusetts to allow for social service workers to receive reports which assure immunity and confidentiality from persons in the community of abuse situations. It does not allow an agency to be designated to handle those kinds of reports. It does not have provisions which then require mandatory investigation and which allow for access where access is denied by a caretaker. At this point, social workers will go to a home on a basic outreach or report and they get there and the caretaker says, “Mom’s fine.” They have no legal recourse to do an investigation, to find out what’s going on in there, without violating confidentiality, and rights of privacy.

Mr. DRINAN. I wonder, has there been some model law proposed by some national group?

Ms. MEYERS. Yes, there has been. There have been model laws, one of the model laws is presently active in North Carolina.

Mr. DRINAN. Has the national group proposed a model law that states adopt?

Ms. MEYERS. Yes, Legal Research and Services has proposed a preliminary one. We are in the process of proposing extensive recommendations that would be getting to the point of a model law to address all these issues. At this point, it is not completed. Other than that, no, there are not many organizations that have taken a look at the issue.

Mr. DRINAN. Well, I would suggest to Kathy Gardner on the staff of the Aging Committee that we might well consider putting out a study document on this and get the Library of Congress involved. We might propose a model law. The Commissioners on model laws are very, very expert in this area and they should be interested. Then a state could not say, oh, we have to do a lot of extensive research. They could just take the model law and then go to the Connecticut law and other laws and they would be ready for enactment, probably.

Ms. MEYERS. I think that would be excellent.

Mr. DRINAN. Thank you very much. The last witness of the morning is Thelma Bailey. She is the Associate Director of the New England Resource Center for Protective Services in Boston.

STATEMENT OF THELMA BAILEY, ASSOCIATE DIRECTOR, NEW ENGLAND RESOURCE CENTER FOR PROTECTIVE SERVICES, BOSTON, MASS.

Ms. Bailey. By now, everyone is good and tired, hungry, restless and I conlose us all for sitting through the morning without changing the schedule. Now, I come to you as the social work professor and currently as co-director of the New England Resource Center for Protective Services which is one of the regional centers established through the National Center on Child Abuse and Neglect. After 30 years of practice as a social worker dealing with those services to the elderly and to children and families, I certainly feel like the historian of the group here.

I do need to correct some of the prior testimony that says that protective services for children is new. Some 102 years ago, Mary Ellen, chained to her bed in New York, was found by a visitor, referred her...
to the American Humane Society who care for animals, the SPCA, because 102 years ago there was not protective services for children. However, you, at that point the national organization was only to prove, not beyond a reasonable doubt, but just to be able to prove with a preponderance of evidence that abuse or neglect exists.

Someone has talked about the fact here that clients resist help. Sure, they resist help. The families will resist the help, the victims themselves will resist help because of their concerns about possible retaliation, because as has been pointed out of their own guilt, they shouldn't have lived so long. They are saying to themselves over and over, 'if I weren't hanging around, at least they'd have my insurance money. If I weren't hanging around, they could use what little there is left, I am eating up all my savings with my medication or whatever.'

This is impressed on the elderly over and over, not by people who mean to do it necessarily, but it's a fact of life. The gas prices are going up. I have an elderly person sitting home tonight and you have been in a gas line all day and you had to pay over a buck a gallon for your gas and you are going to go home and use some saiding oil. Then you need to go to the bathroom for the 10th time that day and some body is disgusted with it. These things are unseen by outsiders. The reports we get are if somebody comes in. The moment we have mandated reporters for children's protective service.

You, the mandated reporters, a physician who might notice some kind of red mark about the buttocks from being jammed down onto a toilet or commode will get reported because it's expected and some people may say, indeed there may be abuse.

Now, we have talked this morning about the difference between neglect and abuse. I could suggest that if the quality of life for any elderly person is diminished in the slightest way because of neglect, it is a concern to us as citizens in this community and in this country, the same as for children. Neglect may not lead to battering, but we deal with many families who neglect members who are vulnerable. They never batter them and we have no evidence because 'ye neglect, ye will eventually batter,' but neglect is enough. Neglect is enough! We don't need to wait until someone is battered. We also know that we need to establish legislation so that we can protect the elderly. We need not wait until we can document that abuse or neglect exists. I do not care to prove who did it. Community outrage would like to prove who did it. We would like to protect the elderly. You cannot do that by having to find out who did it.

Two years ago, I dealt with a case of an infant with 17 stab wounds. I was told that had he lived. I did not see that there would be any question of that. However, the very fine defense attorney for the parents said, 'oh, isn't this terrible, the assault and battery, we must go into court and assaultices and I said, 'oh no, you don't.' I had no way of proving, did the mother do it? Did the father do it? Did the babysitter do it? Did a look on the street come in and do it? But I have never been able to say that he was going to protect that child. Please do not get into any trap in your excitement and outrage if we're going to get those guys who do this or those women who do this by going into the court. If the victim wants the criminal court, they may use it. But please don't obscure with the glare of 'we are going to get the criminals!
rather beat him over the back with a shovel. He could not go to school because the dump is not in the school district. So he had never been to school. I thought of how stupid I was in those early years of practice because I kept putting him in foster homes far away from the dump. All it meant was it took him longer to run home. Kids don't want to be saved, adults don't want to be saved. We must not see ourselves as rescuers, we must have exactly what Dr. Mahoney said in his opening statement, a rational plan. We need to illuminate and not glare. We need to reduce our outrage and in doing this, diminish our man and that we will want to talk or if Mr. Bergman

in another State for 2 1/2 hours one morning about their cases of sexual abuse of children. At the end of that session, 2 1/2 hours of cases, two reporters came up to me, one on either side, and both said the same thing. I had said it was in their State, which was a nasty thing for me to do, but the reporters statement was "it's not in our part of the state, is it?" You are all hoping it's either in the housing projects, or in the country, or in the ghetto, in the combat zone. It's everywhere and the myopia of all citizens needs to be reduced. The outrage needs to be reduced. The very careful planning needs to be increased. That's what I think today represents for each of you. I congratulate you on what you're doing.

Mr. DRINAN. Thank you very much, Mrs. Bailey. They saved the best for the last. I, too, want to congratulate everybody who structured this and Mr. Bergman and all his colleagues who did the extensive study. I can assure you that you've had an impact upon one Congressman and that we will be intensively interested in every development in this area. Before we break for lunch, I wonder if Mr. Bergman will want to talk or if Mr. Steve Day has an announcement.

[Whereupon, at 15 p.m., the briefing was adjourned.]
friends, caretakers, or other household members during the past eighteen months. The report is based upon data gathered from a survey of 194 professionals and paraprofessionals which was conducted during March and April 1979. Five types of information were collected:

1. Professional seeing elder abuse
2. Characteristics of abused elders
3. Characteristics of persons engaging in abuse
4. Brief description of the incident(s)
5. Response(s) to the incident

Thirty-four percent (34%) of the surveys were returned, of which 183 or 55% indicated a citing of elder abuse within the past eighteen months. An additional 19 surveys reported instances of multiple abuse (more than one person being abused) and were not coded for analysis.

In interpreting findings, remember that:

1. The survey was designed to yield descriptive data only. From this type of information other, more analytical studies can be designed regarding the extent of abuse and variables associated with abuse.
2. The 183 cited elder abuse gathered from the survey do not necessarily represent 183 cases of abuse; persons responding to the survey could have been reporting on the same case in some instances.
3. Possibly duplicated case counts (as explained above) mean that only the grossest findings should be accepted with regard to which abuse is occurring.
4. This survey does not represent a random sampling of any population. Therefore all findings generated through the survey must be tested through more controlled research techniques. Survey findings are generalized beyond this data set.

Significant Findings

1. Survey respondents reported 183 citations of elder abuse occurring in Massachusetts over the past eighteen months. (Please note that "citations" do not represent an unuplicated count of abuse cases.)
2. Almost all professionals surveyed indicated that they knew of cases of elder abuse, with visiting nurses, hospital social service directors, private social service agencies and home care corporations accounting for the majority of abuse citations.
3. Incidents of abuse tended to be recurring events and not single occurrences: 78% of the respondents indicated the abuse had occurred twice or more.
4. Outside (third-party) observation tended to be the primary means of identifying abuse cases. In at least 70% of the abuse citations, someone other than the victim or his/her family brought the case to the attention of concerned professionals or paraprofessionals.
5. Physical trauma constituted over 41% of the reported injuries and included bruises, cuts, fractures, burns, punctures, dislocations and lacerations. Other types of abuse included verbal harassment, malnutrition, financial mismanagement, unreasonable confinement, sedation and sexual abuse.
6. Victims of abuse were likely to be very old (75 and over) rather than younger (66-74).
7. Women were more likely to be abused than men, regardless of age.
8. In 75% of the abuse citations, the victim had a mental or physical disability which prevented him or her from meeting daily needs.
9. In 70% of the citations, the victim lived with the abuser and in 84% of the citations, the abusing person was a relative of the victim.
10. Almost three-quarters of the surveys stated that the abuser was experiencing some form of stress such as alcoholism or drug addiction, a long term medical complaint or long term financial difficulties.
11. Often (in 65%) of the surveys, the elder victim was a source of stress to the abuser, primarily because the elder required a high level of physical or emotional care from the abuser (such as personal care, preparation of meals and administering medications) or was financially dependent on the abuser.

12. A wide variety of intervention strategies were described by the respondents, including referral to social service agencies, counselling, arrangements of home and personal services and removal of the victim. Temporary or permanent removal of the victim from the abusive situation was frequently cited.

33. 70% of all surveys indicated that some barrier to service provision was experienced by workers. A particular problem was the reluctance of the victim to acknowledge the problem or allow corrective action to be taken. Assuming a legal protection for workers who wish to intervene in the abuse situations. Earl abuse affecting this population may be present in some abusive situations (impatience of the elder, stress upon the abuser). It is essential, however, that we identify as many as possible and not just the two which formed the basis for this initial survey. By ignoring or inadequately investigating some theories, we may be a potential effective treatment for abuse, since our solutions tend to be determined (and limited) by our explanations for why something occurred. The end product of our research should be, after all, the identification or strengthening of effective means for isolating and treating elder abuse and alleviating the conditions which appear to precipitate it.

INTRODUCTION AND METHODOLOGY

Introduction

This report presents a preliminary analysis of information on the abuse of elders in Massachusetts within the past eighteen months (October 1978 to April 1979). This information was collected through a survey of medical, legal, police and social work professional staff, hospital staff and home care workers. The survey yielded five types of data:

1. Professional seeing elder abuse
2. Characteristics of the abused person (for example: age, sex, race, religion, physical and mental functioning, household composition);
3. Description of the abuse (for example: type of injury sustained by the abused person, nature of the abuse, level of protection for workers and women who wish to intervene in the abuse situation.; Earl abuse affecting this population may be present in some abusive situations.
4. Response(s) to the incident(s) (for example: type of service directed);
5. Survey text and summary tables present the major findings.

Purpose

Little organized knowledge exists to date on the problem of elder abuse, defined as the physical abuse of elderly persons at the hands of their children, other relatives, friends or caretakers. Child battering has received considerable attention over the past fifteen to twenty years since Kempe et al. described the "battered child syndrome." Spouse battering has now been identified as an

other form of familial violence occurring in staggering proportions (estimates of as many as two million cases per year of wife battering have been made by Steinmetz, et al. )

Current literature on violence within the family focuses almost exclusively upon these two forms of abuse. The bulk of this literature describes studies which attempt to identify the causal antecedents to abuse, thus providing a broadening of the definition "why does it happen?" A handful of researchers, however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.

While abuse of elderly living in institutions, such as nursing homes or rest homes, is a phenomenon which receives sporadic attention from the media and government agencies, the problem of elderly who are abused in their own or their family's house has gone largely unnoticed and unrecognized. Little information exists on the extent of the problem, what this form of abuse looks like, who sees it or what can be done about it.

The purpose of this survey is, therefore, to provide preliminary data on the nature of elder abuse. Does the phenomenon "elder abuse" exist and if so, what do people see it as, what does it look like, and what are the characteristics of the abuser and the victim and what action(s) do people take when they recognize that punishment actually occurs, may happen, or when the behavior is distressing to the respondent, may result in a report of mistreatment or injury, such as "beating up hubby"? "How Does Elder Abuse Look Like"? data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

In February, 1979, project staff conducted a literature search on violence in the family, including in particular readings on child abuse and spouse abuse. A review of the literature revealed that several published works which have attempted to identify the causal antecedents to abuse, providing a broadening of the definition "why does it happen?" A handful of researchers, however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.

The purpose of this survey is, therefore, to provide preliminary data on the nature of elder abuse. Does the phenomenon "elder abuse" exist and if so, what do people see it as, what does it look like, and what are the characteristics of the abuser and the victim and what action(s) do people take when they recognize that punishment actually occurs, may happen, or when the behavior is distressing to the respondent, may result in a report of mistreatment or injury, such as "beating up hubby"? "How Does Elder Abuse Look Like"? data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

Instrument Design and Pre-Test

The broadening of the definition to include "willful neglect" and "deprivation of medical care" may therefore inflate the clings of abuse clings through the concept of neglect. Many aspects of trauma seems an appropriate first step in identifying various "modeling" or "types of abuse. The analysis of data does not distinguish between these models.

In the discussion of one question, however, (What Does Elder Abuse Look Like?) data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

In February, 1979, project staff conducted a literature search on violence in the family, including in particular readings on child abuse and spouse abuse. A review of the literature revealed that several published works which have attempted to identify the causal antecedents to abuse, providing a broadening of the definition "why does it happen?" A handful of researchers, however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.

The purpose of this survey is, therefore, to provide preliminary data on the nature of elder abuse. Does the phenomenon "elder abuse" exist and if so, what do people see it as, what does it look like, and what are the characteristics of the abuser and the victim and what action(s) do people take when they recognize that punishment actually occurs, may happen, or when the behavior is distressing to the respondent, may result in a report of mistreatment or injury, such as "beating up hubby"? "How Does Elder Abuse Look Like"? data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

Instrument Design and Pre-Test

The broadening of the definition to include "willful neglect" and "deprivation of medical care" may therefore inflate the clings of abuse clings through the concept of neglect. Many aspects of trauma seems an appropriate first step in identifying various "modeling" or "types of abuse. The analysis of data does not distinguish between these models.

In the discussion of one question, however, (What Does Elder Abuse Look Like?) data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

In February, 1979, project staff conducted a literature search on violence in the family, including in particular readings on child abuse and spouse abuse. A review of the literature revealed that several published works which have attempted to identify the causal antecedents to abuse, providing a broadening of the definition "why does it happen?" A handful of researchers, however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.

The purpose of this survey is, therefore, to provide preliminary data on the nature of elder abuse. Does the phenomenon "elder abuse" exist and if so, what do people see it as, what does it look like, and what are the characteristics of the abuser and the victim and what action(s) do people take when they recognize that punishment actually occurs, may happen, or when the behavior is distressing to the respondent, may result in a report of mistreatment or injury, such as "beating up hubby"? "How Does Elder Abuse Look Like"? data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

In February, 1979, project staff conducted a literature search on violence in the family, including in particular readings on child abuse and spouse abuse. A review of the literature revealed that several published works which have attempted to identify the causal antecedents to abuse, providing a broadening of the definition "why does it happen?" A handful of researchers, however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.

The purpose of this survey is, therefore, to provide preliminary data on the nature of elder abuse. Does the phenomenon "elder abuse" exist and if so, what do people see it as, what does it look like, and what are the characteristics of the abuser and the victim and what action(s) do people take when they recognize that punishment actually occurs, may happen, or when the behavior is distressing to the respondent, may result in a report of mistreatment or injury, such as "beating up hubby"? "How Does Elder Abuse Look Like"? data are separately analyzed in order to provide figures on the relative number of physical abuse clings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

In February, 1979, project staff conducted a literature search on violence in the family, including in particular readings on child abuse and spouse abuse. A review of the literature revealed that several published works which have attempted to identify the causal antecedents to abuse, providing a broadening of the definition "why does it happen?" A handful of researchers, however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.
Mailing lists were compiled with the assistance of state-wide organizations representing these professions. Although duplicate addresses were eliminated whenever possible, approximately 29 agencies received the survey twice. Persons receiving the survey were asked to complete the form within three weeks, making additional copies of the blank survey for each case of elder abuse being reported. No surveys were accepted after May 4, 1979.

Completion rate

Of the 355 surveys returned, 19 were eliminated because more than one citing of elder abuse was reported on each form, making data tabulation difficult. Of the remaining surveys, 183 (52%) reported a citing of elder abuse within the past 18 months. When multiple count surveys (those which were eliminated from analysis) are taken into account, the percentage of returned surveys citing abuse rises to 57%. 169 returned surveys (48%) reported seeing no abuse during the past 18 months.

Unit of analysis

Each reporting on one abused elder is considered to be one citing of abuse. This survey has uncovered 183 such citings, in addition to 19 citings of abuse involving more than one elder (for example, a couple being abused by their son). Citings do not represent unduplicated counts of cases of elder abuse. That is, several survey respondents could have reported on the same case of abuse. It is important to recognize that 183 citings of abuse do not represent 183 elder persons who have been abused. This survey does not lend itself, therefore, to estimating the incidence of elder abuse in Massachusetts. Additional, more controlled studies will be required before estimates of incidence can be made. Because single cases of abuse may have been counted several times, data may be skewed; interpreting survey results, especially in those categories in which a relatively small number of responses were coded, is made more tenuous because of this factor. In general, therefore, analysis of survey data concentrates on the grossest findings, i.e., those in which one data element is overwhelmingly selected by most respondents when a particular question is asked.

Table of generalizations

This survey permits the respondent, abuser and victim to remain anonymous. This was done in order to protect the confidentiality of all respondents. We encourage a higher response rate on the part of survey recipients. Anonymity does mean, however, that survey results are not verifiable.

This survey does not represent a random sampling of any population. Hence, survey results are not generalizable beyond this particular data set. This is especially important to keep in mind in reviewing the findings.

A. Does elder abuse exist?

Initial results indicate that professionals who were surveyed are encountering cases of elder abuse. 183 of the 355 surveys returned (52%) stated that the respondent knew of at least one case of elder abuse occurring during the past 18 months. The abuse cases described ranged from inability or unwillingness of a caregiver (relative or non-relative) to provide essential services to that of repeated physical battering by a family member. The types of mistreatment uncovered by the survey include financial mismanagement, confinement, physical trauma, seclusion, threats of physical harm, abandonment, isolation (over-medication) and sexual abuse.

Perhaps one of the most significant findings of this survey is that incidents of abuse tend to be recurring events and not single occurrences. Of the 1138 surveys citing abuse, 70% indicated that the abuse occurred more than twice. Another 9% reported that the abuse happened at least twice.

While the data do not permit us to estimate the incidence of elder abuse, demographic trends towards an increasing elderly population and the recurrent nature of abuse make it likely that we will see more rather than less of them in the future.

Summary Tables 1 and 2 follow and display data on citings and recurrence of abuse.

SUMMARY TABLE 1—DOES ELDER ABUSE EXIST

<table>
<thead>
<tr>
<th>Number surveys cited</th>
<th>Total surveys returned (n=355)</th>
<th>Percent of total surveys cited (n=183)</th>
<th>Percent of citing abuse (n=332)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>533</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td>2</td>
<td>169</td>
<td>55</td>
<td>64</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

SUMMARY TABLE 2—DOES ELDER ABUSE TEND TO RECUR?

<table>
<thead>
<tr>
<th>Total number surveys</th>
<th>Total surveys analyzed (n=332)</th>
<th>Percent of total surveys cited (n=183)</th>
<th>Percent of citing abuse (n=332)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>533</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td>2</td>
<td>169</td>
<td>55</td>
<td>64</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

B. Who sees elder abuse?

The following charts display the number and percent of surveys sent to each professional/professional group (column A), the number and percent of surveys returned by each profession (column B), the number of abuse citings per profession (column C), and the response rate per profession (column D).

These data indicate that within the past eighteen months, elder abuse was cited by all but one professional/professional group that was surveyed. Some professions, such as visiting nurses, hospital social services directors, and private social service agency staff, were responsible for large numbers of citings of abuse. 169 of the 355 surveys are attributed to these three professional groups. We must bear in mind that these professions also received a proportionately large number of the surveys mailed out (47%) and this may account for the high numbers of citations attributed to them.

ANALYSIS OF SURVEY RESULTS

A. Does elder abuse exist?

Initial results indicate that professionals who were surveyed are encountering cases of elder abuse. 183 of the 355 surveys returned (52%) stated that the respondent knew of at least one case of elder abuse occurring during the past 18 months. The abuse cases described ranged from inability or unwillingness of a caregiver (relative or non-relative) to provide essential services to that of repeated physical battering by a family member. The types of mistreatment uncovered by the survey include financial mismanagement, confinement, physical trauma, seclusion, threats of physical harm, abandonment, isolation (over-medication) and sexual abuse.

Perhaps one of the most significant findings of this survey is that incidents of abuse tend to be recurring events and not single occurrences. Of the 1138 surveys citing abuse, 70% indicated that the abuse occurred more than twice. Another 9% reported that the abuse happened at least twice.

While the data do not permit us to estimate the incidence of elder abuse, demographic trends towards an increasing elderly population and the recurrent nature of abuse make it likely that we will see more rather than less of them in the future.

Summary Tables 1 and 2 follow and display data on citings and recurrence of abuse.
For this reason, we cannot rely solely on absolute numbers of citations per profession in order to understand who sees abuse. Columns C and D are useful in helping us examine our data more carefully.

We see for example in Column D that certain professions have a much higher response rate than others. For example, hospital case managers who received 87 surveys returned 58 of them. This group also reported 74 citations of abuse out of the 28 surveys distributed to them (Column C). This means that 80% of the surveys sent to them were returned and 74% of the surveys sent to them were returned citing abuse. This is a much higher response rate and citation rate than any other profession, even though the absolute number of citations reporting is much less for these health care corporations than for other professions.

Similarly high response and citation rates are found in the professional category labelled "other" which consisted of a small number of health-oriented professionals (such as nurses and medical social workers), hospital officers and other persons who primarily provide services to elders. Visiting nurses, hospital social services directors and home/health aide staff also displayed relatively high rates of response to the survey (Table 4). But in most of these professional groups, had reasonably high abuse citing rates with reference to the number of surveys sent to them.

These data would indicate that as future studies or responses to elder abuse are developed, the professions specifically mentioned above would play a key role both as potential sources of research data and as professions most likely to see and, hence, deal with abuse.

The data displayed on Chart A is also interesting in its negative findings. Surveyed groups which produced the lowest numbers of citations of abuse were emergency room personnel, hospital supervisors, police and welfare protective services managers at the regional level; yet one might expect each of these professions to have seen instances of elder abuse in their role as mediators of family violence. This survey can only raise the obvious question of why these key professions cite so few instances of elder abuse.

While these data provide us with some interesting findings, we remind the reader that in no instance were all members of a profession surveyed. In some cases, only agency directors received surveys; in others (for example) a self-selected and non-representative segment of the profession was surveyed. Additional research will be required, therefore, in order to more accurately determine the relative involvement of each profession in abuse reporting and treatment of the elderly.

Perhaps our most interesting finding in this area was that in at least 70% of the abuse citations, involvement of a third party (someone other than the victim or the victim's/their family) was required before the case was brought to the attention of concerned professionals or paramedical professionals. This suggests the need for additional research on the ways in which abuse is brought to the attention of health professionals.

One form of outside (third party) observation as brought to the respondent's attention. A major portion of the citations were obtained either from personal observation by the respondent (26%) or by a co-worker (19%). Equally remarkable is the small number of referrals made by the legal profession, police and medical doctors as means of reporting abuse. As in our previous discussion (Who Sees Abuse), we ask why certain professions whose abuse might be expected to be called in cases of domestic violence and/or trauma, account for such a small percentage of reports of elder abuse. Is it that these professions do not see abuse, do not recognize it when they see it, or find it difficult to deal with the problem in isolation from other professions? A survey of professionals specifically designated to elicit data from these professions might clarify this question.

We can now turn to a more detailed discussion of the relative involvement of each profession in abuse reporting and treatment of the elderly. Table 3, which follows, displays raw data on the number of abuse citations reported by each professional group.

### Table 3: Who Sees Elder Abuse

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total surveys</th>
<th>Number of surveys returned</th>
<th>Number of surveys returned by profession</th>
<th>Number of abuse citations</th>
<th>Percent of abuse citations reported by profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting nurse</td>
<td>132</td>
<td>132</td>
<td>58</td>
<td>74</td>
<td>56%</td>
</tr>
<tr>
<td>Hospital social services director</td>
<td>183</td>
<td>183</td>
<td>131</td>
<td>125</td>
<td>69%</td>
</tr>
<tr>
<td>Home/health aide staff</td>
<td>30</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>41%</td>
</tr>
<tr>
<td>Hospital social services manager</td>
<td>228</td>
<td>228</td>
<td>151</td>
<td>135</td>
<td>63%</td>
</tr>
<tr>
<td>Emergency room supervisor</td>
<td>163</td>
<td>163</td>
<td>151</td>
<td>104</td>
<td>64%</td>
</tr>
<tr>
<td>Public welfare service director</td>
<td>163</td>
<td>163</td>
<td>151</td>
<td>163</td>
<td>100%</td>
</tr>
<tr>
<td>Project service agency staff</td>
<td>155</td>
<td>155</td>
<td>155</td>
<td>155</td>
<td>100%</td>
</tr>
<tr>
<td>School nurse</td>
<td>143</td>
<td>143</td>
<td>143</td>
<td>143</td>
<td>100%</td>
</tr>
<tr>
<td>Police</td>
<td>109</td>
<td>109</td>
<td>109</td>
<td>30</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>168</td>
<td>168</td>
<td>168</td>
<td>168</td>
<td>100%</td>
</tr>
<tr>
<td>No answer</td>
<td>132</td>
<td>132</td>
<td>132</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>1,044</td>
<td>1,044</td>
<td>999</td>
<td>827</td>
<td>80%</td>
</tr>
</tbody>
</table>

*This indicates the number of surveys included dual professions.*

The need for direct contact with the victim of abuse is indicated by the findings which describe how abuse citations were made. Only 24% of the abuse citations were brought to the respondents' attention by the victim. A major portion of the citations were obtained either from personal observation by the respondent (26%) or by a co-worker (19%). Equally remarkable is the small number of referrals made by the legal profession, police and medical doctors as means of reporting abuse. As in our previous discussion (Who Sees Abuse), we ask why certain professions whose abuse might be expected to be called in cases of domestic violence and/or trauma, account for such a small percentage of reports of elder abuse. Is it that these professions do not see abuse, do not recognize it when they see it, or find it difficult to deal with the problem in isolation from other professions? A survey of professionals specifically designated to elicit data from these professions might clarify this question.
D. What does elder abuse look like?

The most frequently cited injury inflicted on the abused elder was bruises and/or welts (44% of all citations). Debilitating mental anguish followed (40%), with other types of injuries being recorded less frequently. Multiple injuries were frequently cited by respondents. These data are displayed in Summary Table 5 which follows this section.

Chart B below aggregates injury data into six major categories and more clearly distinguishes between the instances in which the elder suffered some physical trauma primarily related to battering and other categories of abuse or neglect, such as malnutrition or freezing.

CHART B

INJURIES SUSTAINED BY THE ABUSED ELDER

<table>
<thead>
<tr>
<th>Injuries</th>
<th>Percent of all Injuries (n=309)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruises and welts: wounds, sutures and punctures; bone fractures; abrasions and lacerations; burns, scalds, etc.</td>
<td>33</td>
</tr>
<tr>
<td>Bone fractures; sprains, dislocations; skin infections; severe burns</td>
<td>12</td>
</tr>
<tr>
<td>Abrasions; minor (bruises, welts, cuts, punctures; scratches; lacerations; burns; blistering); subconjunctival hemorrhages</td>
<td>15</td>
</tr>
<tr>
<td>Debilitating mental anguish, depression</td>
<td>29</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>14</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>8</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>1</td>
</tr>
</tbody>
</table>

This table and present data on all categories of Injuries; therefore columns total have been omitted.

We see that physical trauma constituted 41% of all reported injuries, 34% of the Injuries are minor trauma such as bruises, welts, cuts or punctures, while 7% are major trauma including skull or other fractures and dislocations. The categories labelled "none apparent" (no apparent injury) and "other" tended to be used to describe incidents in which no apparent physical injury could be identified, but in which the respondent felt that "injury" had taken place. "Injury" was sometimes of a serious nature (e.g., permitting an elder to return in his/her own feces) but more often than not was left uncharacterized by the respondent.

In addition to analyzing the injuries sustained by the abused victim, research staff reviewed narrative descriptions of the abuse situation provided by respondents. In reading these brief narratives, staff attempted to classify abuse into the most frequently occurring types or models. Each abuse citation was classified into 1 of 7 categories. The primary presenting problem was unique in 33 of the 183 citations of abuse, but in 66 citations, physical trauma in which the elder

SUMMARY TABLE 5 WHAT DOES ELDER ABUSE LOOK LIKE?

<table>
<thead>
<tr>
<th>Injuries</th>
<th>Percent of all Injuries (n=309)</th>
<th>Percent of total abuse (n=183)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruises and welts: wounds, sutures and punctures; bone fractures; abrasions and lacerations; burns, scalds, etc.</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>Bone fractures; sprains, dislocations; skin infections; severe burns</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Abrasions; minor (bruises, welts, cuts, punctures; scratches; lacerations; burns; blistering); subconjunctival hemorrhages</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Debilitating mental anguish, depression</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

1 Indicates respondents checked multiple injuries.

had been battered in some manner was the presenting condition. 20 citations were primarily verbal harassment, 16 were citations in which neglect was the chief complaint, 8 constituted financial mismanagement (such as withholding rent and food money from the elder) and 7 were primarily characterized as unreasonable confinement. Over-relation and sexual abuse occurred in 1 citation each.

These data clearly indicate that visible injury to the elder may be present in a large proportion of abuse cases and may serve as a clue to helping practitioners identify such cases.

B. Characteristics of the abused person

In the survey, elder was defined as anyone 60 years of age or older. The survey divided age categories into: under 60, 60-69, 70-74, 75-79 and 80 and over. Results indicate that the largest single age group represented in the survey were elders over 60 years of age, with 66 citations (36% of all abuse citations). The next largest category, ages 75-79, contained 39% of the citations. The smallest age group represented in the abuse citations was the 60 and under category with 9%. These data are presented in Summary Table 6 which is included at the end of the discussion of age and sex.

One reason for examining the abused person's age is to see if abuse occurs in any other age group than another. Survey results appear to indicate that this may be true for the "over 80" age group.

The number of abuse citations in any age group can, however, simply be a reflection of the relative size of that age group with reference to the total elder population. That is, we may have uncovered more citations of abuse in the over 80 population because that population represents a proportionately large segment of all elders over 60 years of age.

In order to correct for this, we have compared the ratio of abuse citations in each age group over both abuse citations with national census statistics on the proportion of elders over 60 years of age who fall within each of 5 age categories. This comparison is depicted in Figure 1.

![Figure 1](https://example.com/figure1.png)

Figure 1. Comparison of the proportion of abuse citations within each age group with the proportion of national population in each age group.

If abuse occurs in all age groups over 60 with the same frequency, we expect our findings to mirror the composition of the general population over 60: two relatively parallel lines would emerge in figure 1. This is not the case. Population figures would suggest. We also find a proportionately greater number of abuse citations in the 75 and over age groups than population figures would suggest. These data, while by no means definitive, tend to support the conclusion that victims of abuse are more likely to be very old (75 and over) rather than younger (60-75).
Summary Table 7 shows that in 80% of the 1,238 citations of abuse the person who had been abused was female. National census figures indicate, however, that women account for only 55% of the population 65 years of age or older.

Survey data seem to indicate that women may represent a proportionately larger share of the abused population than their numbers in the general population would suggest.

In order to examine these data more carefully, the data from which this figure was constructed. The figure illustrates that within each age group, the proportion of females in the abused population exceeds the proportion which general population statistics would suggest.

In interpreting both age and sex data, readers are cautioned to remember—

—this was not a random sampling of the abused or elder population so did it produce an unduplicated count of individual cases. Results may therefore be skewed in some undetermined way.

—it may be that women are more likely to seek assistance or report abusive behavior than men, thus increasing the number of citations in which women appear as the victim of abuse.

—the client population of the professions surveyed may be composed largely of women and/or "very old" elderly, thus skewing our results in these directions.

Additional research will be needed to confirm these findings.

Summary Table 6—Age Distribution of Abused Persons Compared with Age Distribution of General Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Citings</th>
<th>Percent of Total Citings</th>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 51</td>
<td>315</td>
<td>63%</td>
<td>146</td>
<td>83%</td>
</tr>
<tr>
<td>51 to 64</td>
<td>146</td>
<td>29%</td>
<td>100</td>
<td>61%</td>
</tr>
<tr>
<td>65 and over</td>
<td>146</td>
<td>29%</td>
<td>183</td>
<td>108%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Citings</th>
<th>Percent of Total Citings</th>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>382</td>
<td>42%</td>
<td>146</td>
</tr>
<tr>
<td>65 to 69</td>
<td>257</td>
<td>29%</td>
<td>100</td>
</tr>
<tr>
<td>70 to 74</td>
<td>216</td>
<td>25%</td>
<td>100</td>
</tr>
<tr>
<td>75 to 79</td>
<td>199</td>
<td>23%</td>
<td>100</td>
</tr>
<tr>
<td>80 and over</td>
<td>95</td>
<td>11%</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>146</td>
</tr>
<tr>
<td>65 to 69</td>
<td>100</td>
</tr>
<tr>
<td>70 to 74</td>
<td>100</td>
</tr>
<tr>
<td>75 to 79</td>
<td>100</td>
</tr>
<tr>
<td>80 and over</td>
<td>100</td>
</tr>
</tbody>
</table>

Abused Population in Survey

National Population (1977 Nat'l Census Figures)

80% of the abused population was female. National census figures indicate, however, that women account for only 55% of the population 65 years of age or older. Survey data seem to indicate that women may represent a proportionately larger share of the abused population than their numbers in the general population would suggest.

In order to examine these data more carefully, the data from which this figure was constructed.

The figure illustrates that within each age group, the proportion of females in the abused population exceeds the proportion which general population statistics would suggest.

In interpreting both age and sex data, readers are cautioned to remember—

—this was not a random sampling of the abused or elder population so did it produce an unduplicated count of individual cases. Results may therefore be skewed in some undetermined way.

—it may be that women are more likely to seek assistance or report abusive behavior than men, thus increasing the number of citations in which women appear as the victim of abuse.

—the client population of the professions surveyed may be composed largely of women and/or "very old" elderly, thus skewing our results in these directions.

Additional research will be needed to confirm these findings.

Summary Table 6—Age Distribution of Abused Persons Compared with Age Distribution of General Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Citings</th>
<th>Percent of Total Citings</th>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 51</td>
<td>315</td>
<td>63%</td>
<td>146</td>
<td>83%</td>
</tr>
<tr>
<td>51 to 64</td>
<td>146</td>
<td>29%</td>
<td>100</td>
<td>61%</td>
</tr>
<tr>
<td>65 and over</td>
<td>146</td>
<td>29%</td>
<td>183</td>
<td>108%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Citings</th>
<th>Percent of Total Citings</th>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>382</td>
<td>42%</td>
<td>146</td>
</tr>
<tr>
<td>65 to 69</td>
<td>257</td>
<td>29%</td>
<td>100</td>
</tr>
<tr>
<td>70 to 74</td>
<td>216</td>
<td>25%</td>
<td>100</td>
</tr>
<tr>
<td>75 to 79</td>
<td>199</td>
<td>23%</td>
<td>100</td>
</tr>
<tr>
<td>80 and over</td>
<td>95</td>
<td>11%</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>146</td>
</tr>
<tr>
<td>65 to 69</td>
<td>100</td>
</tr>
<tr>
<td>70 to 74</td>
<td>100</td>
</tr>
<tr>
<td>75 to 79</td>
<td>100</td>
</tr>
<tr>
<td>80 and over</td>
<td>100</td>
</tr>
</tbody>
</table>

Abused Population in Survey

National Population (1977 Nat'l Census Figures)

80% of the abused population was female. National census figures indicate, however, that women account for only 55% of the population 65 years of age or older. Survey data seem to indicate that women may represent a proportionately larger share of the abused population than their numbers in the general population would suggest.

In order to examine these data more carefully, the data from which this figure was constructed.

The figure illustrates that within each age group, the proportion of females in the abused population exceeds the proportion which general population statistics would suggest.

In interpreting both age and sex data, readers are cautioned to remember—

—this was not a random sampling of the abused or elder population so did it produce an unduplicated count of individual cases. Results may therefore be skewed in some undetermined way.

—it may be that women are more likely to seek assistance or report abusive behavior than men, thus increasing the number of citations in which women appear as the victim of abuse.

—the client population of the professions surveyed may be composed largely of women and/or "very old" elderly, thus skewing our results in these directions.

Additional research will be needed to confirm these findings.

Summary Table 6—Age Distribution of Abused Persons Compared with Age Distribution of General Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Citings</th>
<th>Percent of Total Citings</th>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 51</td>
<td>315</td>
<td>63%</td>
<td>146</td>
<td>83%</td>
</tr>
<tr>
<td>51 to 64</td>
<td>146</td>
<td>29%</td>
<td>100</td>
<td>61%</td>
</tr>
<tr>
<td>65 and over</td>
<td>146</td>
<td>29%</td>
<td>183</td>
<td>108%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Citings</th>
<th>Percent of Total Citings</th>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>382</td>
<td>42%</td>
<td>146</td>
</tr>
<tr>
<td>65 to 69</td>
<td>257</td>
<td>29%</td>
<td>100</td>
</tr>
<tr>
<td>70 to 74</td>
<td>216</td>
<td>25%</td>
<td>100</td>
</tr>
<tr>
<td>75 to 79</td>
<td>199</td>
<td>23%</td>
<td>100</td>
</tr>
<tr>
<td>80 and over</td>
<td>95</td>
<td>11%</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male Population</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>146</td>
</tr>
<tr>
<td>65 to 69</td>
<td>100</td>
</tr>
<tr>
<td>70 to 74</td>
<td>100</td>
</tr>
<tr>
<td>75 to 79</td>
<td>100</td>
</tr>
<tr>
<td>80 and over</td>
<td>100</td>
</tr>
</tbody>
</table>
### TABLE 8—DOES THE ABUSED PERSON HAVE A MENTAL OR PHYSICAL DISABILITY WHICH PREVENTS THEM FROM MEETING DAILY NEEDS?

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>118</td>
<td>76</td>
</tr>
<tr>
<td>No</td>
<td>67</td>
<td>43</td>
</tr>
<tr>
<td>NA</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>196</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### TABLE 9—DISABILITY ACROSS AGE GROUPS

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Abuse citation</th>
<th>Physical/mental citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>15 to 19</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>20 to 29</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>30 to 39</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>40 to 49</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>50 to 59</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>60 to 69</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>70 to 79</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>80 and over</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>183</td>
<td>183</td>
</tr>
</tbody>
</table>

### TABLE 10—RACE OF ABUSED PERSONS

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of citations (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Black</td>
<td>48</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>50</td>
<td>28</td>
</tr>
<tr>
<td>White</td>
<td>100</td>
<td>55</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>NA</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>183</td>
<td>100</td>
</tr>
</tbody>
</table>

### TABLE 11—RELIGION OF ABUSED PERSON

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number of citations (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewish</td>
<td>47</td>
<td>25</td>
</tr>
<tr>
<td>Catholic</td>
<td>34</td>
<td>18</td>
</tr>
<tr>
<td>Protestant</td>
<td>30</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>NA</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>183</td>
<td>100</td>
</tr>
</tbody>
</table>

### TABLE 12—DOES SUBJECT LIVE WITH OTHERS?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>137</td>
<td>75</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>25</td>
</tr>
<tr>
<td>NA</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>194</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### TABLE 13—DOES SUBJECT HAVE FAMILY, FRIENDS OR RELATIVES OUTSIDE THE HOUSEHOLD?

<table>
<thead>
<tr>
<th>Presence</th>
<th>Number (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>135</td>
<td>73</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>25</td>
</tr>
<tr>
<td>NA</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>193</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### SUMMARY Table 14—WHO RESIDES AT THE SAME ADDRESS AS SUBJECT?

<table>
<thead>
<tr>
<th>Resident</th>
<th>Number (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>135</td>
<td>73</td>
</tr>
<tr>
<td>Wife</td>
<td>135</td>
<td>73</td>
</tr>
<tr>
<td>Son</td>
<td>50</td>
<td>27</td>
</tr>
<tr>
<td>Daughter</td>
<td>35</td>
<td>19</td>
</tr>
<tr>
<td>Other relative</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>NA</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>183</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### TABLE 15—APPROXIMATE INCOME OF HOUSEHOLD

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Number (n=183)</th>
<th>Percent of total citations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $500</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>$500 to $999</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>$1000 to $1999</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>$2000 to $2999</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>$3000 to $3999</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>$4000 to $4999</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>$5000 to $5999</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>$6000 to $6999</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>$7000 to $7999</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>$8000 to $8999</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>$9000 to $9999</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>$10,000 or more</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>NA</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>183</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Income of Household

The surveys indicated that 27% of the households where older adults had occurred received incomes of less than $5,000. This question, apparently to be the most difficult question for professionals to answer with a very high no response rate. 68 surveys (37%) failed to respond.

Income findings are supported by the latest census information on income. In the 1970 National Census Report over 60% of those over 65 earned less than $5,000. Census information also showed that the average income of elderly women was significantly lower than elderly men. An interesting hypothesis might be whether the greater financial dependence of women on their families could be a factor which helps to explain the higher proportion of abused women to men which our survey found. The results of the survey do not lend themselves to this conclusion but at least indicate that further research may be warranted.

It is possible that many of the professionals who responded to the survey were primarily low-income clients. If that is the case, our findings on income would merely represent the income classes reached by the survey and not the true population of abused elderly. It is important that the results not be construed to mean that poor elderly are most likely to be abused. Such a conclusion requires more controlled and precise research into this question.

Summary Table 15, which precedes this section, displays data on income of the abused person's household.
F. Information on the abuser
Living arrangement and relationship of abuser to the abused

In 75% (137) of the abuse citations the abuser lived with the person he or she was abusing. In 40% of the citations, the abusing person was a relative of the abused. Sons, husbands and daughters were the largest categories of abusers, accounting for 24%, 20%, and 15% of all abusers. Non-relatives accounted for only 14% of abusing persons. In approximately 1 in every 10 citations of abuse, the abuse was inflicted by more than one person.

While these data indicate that relatives are more likely to be abusers than non-relatives, it may be that living arrangement is a more pertinent variable than relationship in explaining the abusive situation. In that case, results indicating that a high proportion of abusers tend to be relatives may only reflect the fact that elders, especially elders requiring care, tend to live with their families.

Certainly, however, data collected from this survey indicate that elders living with their relatives may constitute a significant portion of the abused population. Tables 16 and 17 display these data and are included at the end of section II.

Stress

The survey also indicated that the abuser was usually experiencing some form of stress when the abuse occurred. 29% of the abuse citations indicated that the abuser was experiencing alcoholism or drug addiction at the time the abusive act occurred. Long-term medical complaints and long-term financial difficulties were also leading categories of stress checked by the respondents. Table 18 displays data on stress being experienced by the abuser.

Because duplicate reporting of individual cases of abuse could have skewed responses to this question, the frequency with which each stress category was checked is less significant than the fact that stress, as we defined it, was present in 74% of the abuse citations. While the relative ranking of stressful conditions remains unclear, stress itself appears to be a potential factor in the abusive situation.

Was the elderly a source of stress?

Table 19 shows that in 116 (63%) of the surveys which cited abuse the elderly subject (the person being abused) was a source of stress to the abuser. When asked to explain how the subject was a source of stress, 48% of the surveys indicated that the elderly victim required a high level of physical and emotional care from the abuser (such as personal care, preparing meals, administering medication). In addition, another 15% of the surveys indicated that the elderly victim was either financially dependent on the abuser or had severe physically debilitating conditions which acted as a source of stress for the abuser. Summary Table 20 displays these findings.

We also know (see the discussion on Characteristics of the Abused) that 5% of the surveys citing abuse described the victim as having a mental or physical handicap which impaired daily functioning. These two pieces of data would indicate that impairment of the elderly victim as it impairs upon the abuser may be a relevant variable for further analysis.

Other ways cited in which the elderly contributes to the stress of the abuser: nagging, demanding, manipulative behavior on the part of the elderly; previous family history of arguments over specific issues (e.g., gambling, alcoholism); control of financial assets within the family, and arguments over placement or services for the elderly. Each of these types of behavior may constitute variables which are at work in the abusive situation.

Other forms of violence

84% of the respondents either did not know whether other types of violent behavior were present in the abuser's family or stated that no other violence was known to them. This question was ambiguously worded and does not yield itself to interpretation. Summary Table 21 presents raw data on this question.

[Tables and figures omitted]
G. Action taken when elder abuse is encountered

**Action taken**

Most of the 131 surveys citing abuse indicated that more than one type of action had been taken by the respondent in dealing (or attempting to deal) with the abusive situation. In 62% of the citations, some form of direct action was taken. 23% of the surveys stated that emergency action was taken and 48% of the surveys indicated that a referral was made. Data was further analyzed to identify specific action or recommendations made by the respondent, whether those recommendations were accepted by the abused person or his/her family. Summary Tables 22 and 23 which follow Section D display this information.

Under "direct action" the single step most often taken or recommended was described as placement in a nursing home, a temporary housing or mental health facility, 36% of all direct action included placing or attempting to place the victim elsewhere. Arranging for in-home services (homemakers, chore, meals on wheels, visiting nurses or home health aides) constituted 22% of all direct actions. Coordination of emergency treatment plans (16%), counseling or speaking with the abusing individual (15%) and speaking with the victim (13%) were also cited as forms of direct action.

One half (50%) of all "emergency action" included removal or recommended removal of the victim from the home. Reasons for removal included: medical treatment in a hospital emergency room or hospital/hospitalization (38% of all emergency action), nursing home placements (15%), or other placement, such as public housing (19%). Other types of emergency action included calling the police, calling a crisis team or support team and arranging for the household to call 116.

In surveys which cited "referral" as the type of action taken, referral to social services agencies was the most frequently cited. A breakdown of referrals being made to these agencies. Social services agencies cited included: mental health clinic staff, home health care corporation, local social services, family services, visiting nurses and public welfare.

**SUMMARY TABLE 22.** -- **DOES THE RESPONDENT KNOW OF ANY OTHER INCIDENT OF VIOLENCE OR ABUSE WITHIN THE IMMEDIATE FAMILY OF THE ABUSER?**

<table>
<thead>
<tr>
<th>Type of action</th>
<th>Number</th>
<th>Percent of total cases (n=131)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>62</td>
<td>47%</td>
</tr>
<tr>
<td>No</td>
<td>69</td>
<td>53%</td>
</tr>
<tr>
<td>Total</td>
<td>131</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Legal services** (including legal services agencies, private attorneys, courts and probation, departments) represented 36% of all referrals. Police representation represented 22% of referrals. Perhaps the most interesting feature of these data is what it tells us about the wide variety of responses which elder abuse elicits in the professionals who handle services and removal of the victim appear to be the most frequently responses were appropriate to the specific cases being discussed, a function of what services were available in a given area, or a function of the respondent's professional bias or "style." This is a question which our survey cannot answer.

The wide disparity in skills, approaches and attitudes among respondents is also indicated by the range of responses which we received. Confronting the approach, others called in crisis teams to evaluate the victim and establish various options, whether this wide range of responses to abuse is due to the variety of professional bias, or the various levels of family support available to the victim is not clear.

A second interesting finding is the degree to which placement (temporary or permanent) becomes the most frequently response was taken, in the abuse situation. This survey does not permit us to assess the appropriateness of these placements, but in some instances respondents themselves indicate their place of refuge or resort for the victim.

**Barriers to service**

One-hundred and twenty-nine (79%) of surveys reporting elderly abuse indicated that some barrier to service provision was experienced by workers. 46 surveys responded with a "no answer" to the question. 4 surveys and no barriers existed.

Of those surveys which reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "error in referral" from the abused person, or simply a refusal to accept services.

Three-quarters percent of the surveys which indicated that a legal problem constituted the barrier to care. Legal problems included:

- Lack of legal protection for workers who intervene in the family situation;
- Inability to file a form (lack of proof) when abused person refuses to file complaint;
- Lack of appropriate person to accept guardianship for the elder (this was cited 4 times);
- Requirement of a formal complaint from the abused individual before police can act;
- Unwillingness of witness to testify;
- Absence of formalized statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and telling him/her to stop abusing the victim was one respondent's approach; others called in crisis teams to evaluate the victim and establish various options, whether this wide range of responses to abuse is due to the variety of professional bias, or the various levels of family support available to the victim is not clear.

One-hundred and twenty-nine (79%) of surveys reporting elderly abuse indicated that some barrier to service provision was experienced by workers. 46 surveys responded with a "no answer" to this question. 4 surveys and no barriers existed.

Of those surveys which reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "error in referral" from the abused person, or simply a refusal to accept services.

Three-quarters percent of the surveys which indicated that a legal problem constituted the barrier to care. Legal problems included:

- Lack of legal protection for workers who intervene in the family situation;
- Inability to file a form (lack of proof) when abused person refuses to file complaint;
- Lack of appropriate person to accept guardianship for the elder (this was cited 4 times);
- Requirement of a formal complaint from the abused individual before police can act;
- Unwillingness of witness to testify;
- Absence of formalized statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and telling him/her to stop abusing the victim was one respondent's approach; others called in crisis teams to evaluate the victim and establish various options, whether this wide range of responses to abuse is due to the variety of professional bias, or the various levels of family support available to the victim is not clear.

One-hundred and twenty-nine (79%) of surveys reporting elderly abuse indicated that some barrier to service provision was experienced by workers. 46 surveys responded with a "no answer" to this question. 4 surveys and no barriers existed.

Of those surveys which reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "error in referral" from the abused person, or simply a refusal to accept services.

Three-quarters percent of the surveys which indicated that a legal problem constituted the barrier to care. Legal problems included:

- Lack of legal protection for workers who intervene in the family situation;
- Inability to file a form (lack of proof) when abused person refuses to file complaint;
- Lack of appropriate person to accept guardianship for the elder (this was cited 4 times);
- Requirement of a formal complaint from the abused individual before police can act;
- Unwillingness of witness to testify;
- Absence of formalized statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and telling him/her to stop abusing the victim was one respondent's approach; others called in crisis teams to evaluate the victim and establish various options, whether this wide range of responses to abuse is due to the variety of professional bias, or the various levels of family support available to the victim is not clear.

One-hundred and twenty-nine (79%) of surveys reporting elderly abuse indicated that some barrier to service provision was experienced by workers. 46 surveys responded with a "no answer" to this question. 4 surveys and no barriers existed.

Of those surveys which reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "error in referral" from the abused person, or simply a refusal to accept services.

Three-quarters percent of the surveys which indicated that a legal problem constituted the barrier to care. Legal problems included:

- Lack of legal protection for workers who intervene in the family situation;
- Inability to file a form (lack of proof) when abused person refuses to file complaint;
- Lack of appropriate person to accept guardianship for the elder (this was cited 4 times);
- Requirement of a formal complaint from the abused individual before police can act;
- Unwillingness of witness to testify;
- Absence of formalized statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and telling him/her to stop abusing the victim was one respondent's approach; others called in crisis teams to evaluate the victim and establish various options, whether this wide range of responses to abuse is due to the variety of professional bias, or the various levels of family support available to the victim is not clear.
### SUMMARY TABLE 22—WHAT ACTION DID THE RESPONDENT TAKE?

<table>
<thead>
<tr>
<th>Action Taken</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical or Hospitalization</td>
<td>114</td>
<td>62</td>
</tr>
<tr>
<td>Arranged in-home services</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Emergency response</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Police services</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Placement</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Existed or abandoned roaming</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Remaining placement</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Emergency shelter</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Police or support team</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>183</td>
<td>100</td>
</tr>
</tbody>
</table>

### SUMMARY TABLE 23—ADDITIONAL ANALYSIS OF REFERRALS

<table>
<thead>
<tr>
<th>Referral</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>65</td>
</tr>
<tr>
<td>Police services</td>
<td>17</td>
</tr>
<tr>
<td>Filing of police complaint</td>
<td>5</td>
</tr>
<tr>
<td>Medical or hospitalization</td>
<td>6</td>
</tr>
<tr>
<td>Legal services</td>
<td>12</td>
</tr>
<tr>
<td>Referral other</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>183</td>
</tr>
</tbody>
</table>

### SUMMARY TABLE 24—BARIERS TO SERVICE PROVIDERS

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number</th>
<th>Percent of total</th>
<th>Percent of total referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses cited barrier</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Rearranged services by abuser</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Lack of funds or resources</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Lack of services</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Lack of support of family</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Abused rages hospitalization</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Other</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
1. I am a:
- visiting nurse
- hospital social services director
- home care corporation staff
- staff nurse
- community mental health center staff
- private social service agency staff
- social worker
- lawyer/paralegal
- police officer
- other (specify)

2. I know of no cases of elder abuse.

3. I do know of at least one case of suspected elder abuse.

4. Who brought this case to your attention:
- personal observation
- co-worker
- subject (self-report)
- member of subject's family
- subject's friend or neighbor
- private agency (specify)
- public agency (specify)
- hospital or clinic
- police
- private medical doctor
- lawyer/paralegal
- other (specify)

5. Check injuries sustained by the subject:
- none apparent
- bruises, welts
- sprains, dislocations
- malnutrition
- burns, holding
- broken bones, fractures
- bone fractures
- skull fractures
- debilitating mental anguish
- sexual abuse
- other (specify)

6. Give brief description of abuse:


8. Race:
- Native American
- Black
- Latino/Latina
- Asian
- Native American
- Other (specify)

9. Religion:
- Catholic
- Protestant
- Jewish
- other (specify)

10. Sex:
- Male
- Female

11. Does the subject have a physical or mental disability which prevents him or her from meeting daily needs: yes no

12. Does the subject have family, friends or relatives outside the household: yes no

13. Has the abuse happened more than once: once twice more than twice

14. Does the subject live with others: yes no

15. If YES, who resides at the same address?

16. What is the approximate income of the household:

17. Does the abuser live with the subject: yes no

18. Relation of abuser to subject:
- husband
- other relative (specify)
- wife
- non-relative (specify)
- daughter
- daughter-in-law
- other relative (specify)

19. Was the abuser experiencing any of the following:
- long term disability
- recent loss of medical assistance
- recent loss of employment
- recent loss of income
- recent loss of home
- recent loss of family
- recent suicide attempt
- recent death of family
- history of alcohol abuse
- history of drug abuse
- other (specify)
Violence within the family is a relatively recent subject of social concern. The majority of "the home", the autonomy and private nature of the family, is a far older concept than that of family violence as a problem requiring some form of social intervention.

As Steinmetz points out, in the 1960s we "discovered" child abuse: in the 1970s we have added spouse abuse and now we see the problem of elder abuse being raised by concerned practitioners. All are forms of familial violence, although certainly child and elder abuse are not limited to a family context. We have in common a victim who more often than not is economically dependent, politically weak and lacking in adequate legal protection.

While sociological and psychological literature documents a high incidence of violence among family members (50 percent of all homicides are committed by family members or lovers), there has been little systematic research into the dynamics of violence among family. Of the three categories of family violence, certainly child abuse has received the most attention in recent years. Traits of the child and the abusing parent are being examined as possible causal factors which would help us explain the existence of this form of abuse. Researchers are also exploring the sources of environmental or societal stress which may be associated with abusive families. While spouse abuse (wife beating or husband beating) has yet to receive the same degree of attention, one can predict that this will become an increasingly important field of study as societal concern makes itself felt.

The recognition of elder abuse within the family context is at an even earlier stage of development. A handful of authors in England and in the United States, most notably Steinmetz and Block, have raised the issue and are conducting preliminary research which will enable us to better describe elder abuse. Others (Brody, Tren, Frankel, and Johnson and Burks) have described the changing relationship of the family vis a vis its oldest generation and the stresses which may produce abuse.

As yet, however, little is known about elder abuse: we do not know what it looks like, how often it happens, who does it, in whom it happens or what mixture of variables tends to occur in conjunction with the abusive act. Until answers to these questions are found, treatment modes will tend to follow those used in dealing with other forms of domestic violence, and adaptations to existing services and legal systems will likely be made in piecemeal fashion, if at all.

Lessons learned from child and spouse abuse may help us frame our approaches to elder abuse and may give practitioners some guidance in dealing with this problem when they encounter it. Our literature review focuses primarily, therefore, on studies which attempt to identify variables associated with family violence and their implications for practice.

**Child Abuse**

Child abuse can be broadly defined as: any mistreatment, physical or mental, brought about through acts of commission or omission by parents or other care givers or more narrowly defined as: intentional, non-accidental use of physical force. In either definition, the line between physical abuse and willful neglect is often difficult to draw, as the list of definitions which accompanies this review shows. Most definitions of abuse appear to include, however, a reference to physical trauma, willfully inflicted. A deliberate act has occurred leading to physical injury of the child (e.g., beating, burning). Definitions of neglect more often focus on the withholding of care. As we move from child abuse to spouse abuse, "neglect" disappears from the vocabulary (perhaps because spouse, as
are relevant. Hate (punishment vs. prevention) have emotional dealing with developed state laws, statutes liability, of radiology. Researchers and practitioners disagree on the importance of intervention, of intensity.

Systematic examples of the last fifteen years, to the enactment of child-abuse reporting laws in all states, which reflect a recognition of the need to record cases. This theoretical approach has implications for the intervention strategies which we select to deal with child abuse.

Several authors have pointed out the need to coordinate services at the community level and have called for the provision of intensive family support systems as an alternative to separation of the parent and child. Many cite the need to involve a wide range of professionals and paraprofessionals in the treatment plan and others call for the development of adequate respite care facilities similar to those found in Great Britain.

General agreement seems to exist that the family is the critical unit for treatment of child abuse cases and that a wide variety of professionals must be available to high risk families: parenting education, legal counseling, financial assistance, psychiatric treatment, emergency shelter care, homework help, day care, and foster homes. Practitioners are questioning the role of "weekly therapy" and have moved toward a more intensive strategy in abuse or neglect cases, realizing that such isolated efforts to care may not begin to address the problems which resulted in abusive behavior. The long term nature of treatment is cited as the relative cost to society of such long-term interventions. Nevertheless, the issue of whether we are indeed willing to shoulder the cost and to look seriously at the cultural and societal issues beyond the level of individual cases.

Gelles and other theoreticians criticize this type of analysis because it ignores the sociological and contextual variables which are associated with the phenomenon of child abuse. In his summary of the literature Gelles cites Thomas, Lystad and others who have pointed out the need to coordinate services at the community level and have called for the provision of intensive family support systems as an alternative to separation of the parent and child. Many cite the need to involve a wide range of professionals and paraprofessionals in the treatment plan and others call for the development of adequate respite care facilities similar to those found in Great Britain.

General agreement seems to exist that the family is the critical unit for treatment of child abuse cases and that a wide variety of professionals must be available to high risk families: parenting education, legal counseling, financial assistance, psychiatric treatment, emergency shelter care, homework help, day care, and foster homes. Practitioners are questioning the role of "weekly therapy" and have moved toward a more intensive strategy in abuse or neglect cases, realizing that such isolated efforts to care may not begin to address the problems which resulted in abusive behavior. The long term nature of treatment is cited as the relative cost to society of such long-term interventions. Nevertheless, the issue of whether we are indeed willing to shoulder the cost and to look seriously at the cultural and societal issues beyond the level of individual cases.
SEXUAL ABUSE

During the past several years, spouse abuse (of both sexes) has received attention, perhaps first from members of the women's movement and then from practitioners, researchers and legislators. Data are scarce, but what data can be found support the conclusion that spouse beating is as widespread a problem as child abuse. "Boston City Hospital has reported that 70% of their emergency room assault victims are female beaten in the home, usually by a husband or lover. In Atlanta, 80% of all police calls received on the night shift are reporting domestic disputes; in Boston, calls average about 15 or 20, or 1727 a year. Almost one third of all female homicide victims in California in one recent year were murdered by their husbands."

Sterns, Slenks and Gelles report that 8.5% of the women in over 5000 American families surveyed "had sustained at least one attack by their husbands in the previous year". This translates into nearly two million beaten wives each year in the United States. The study also found that husbands were as likely to be on the receiving end of violence with wives, being somewhat more frequent in winter and summer and in divorce cases. Within the two categories of spouse abuse (wife/husband) certainly research and literature tends to focus on the wife as victim.

As in child abuse, there are myths or stereotypes about wife abuse. Just as we distinguish battered children or their abusers from the general population, and that poor physical health may be more of a factor than 'masochism' in their inability to break away from a violent situation. Parker and Schumacher note that state is little known about the variables that distinguish battered spouses or their abusers from the general population. As in child abuse, a number of theories have been developed to explain how a battered wife syndrome. Parker and Schumacher define battered wife syndrome as "deliberate, severe, and repeated (more than three times) demonstrable injury from the husband, with the minimal injury being severe bruising."

Theories or models of violence explain this violence as a normal function in verbal communication between spouses; other theories relate wife abuse to the social or cultural mores of a society or to the norms of the individual. As in the case of child abuse, a learned role model, in one of the few controlled studies we know of, Parker and Schumacher found that a "learned role model" may indeed be a relevant factor of these cases. Their study demonstrated that if the abuser was a victim of the battered wife syndrome, there is a statistically significant probability that the wife will be battered by her husband. The study controlled for education level and alcohol by the husband in the variability of abuse.

If wife abuse is vertically transmitted as a learned response from mother to daughter, there may be certain direct implications for practitioners. Primary care physicians, as Parker and Schumacher point out, might be able to break the cycle of violence if medical histories elicited information on patterns of abuse, as this may, in the future, become a legal requirement. Parker and Schumacher define battered wife syndrome as "deliberate, severe, and repeated (more than three times) demonstrable injury from the husband, with the minimal injury being severe bruising."

Society's response to the "discovery" of spouse abuse appears to be following a pattern similar to that of child abuse: first the media, then practitioners, social workers, police, and finally, legislation. Legal remedies are being explored while, at the same time, the victim protection from continued physical assault, does require immediate police and court intervention at the request of the victim. Observers in states such as Massachusetts, however, where family courts have been given the power to intervene in cases of violence, have found that each of us may be wearing two hats: one as a wife, the other as a legal remedy in itself may not be an adequate response to spouse abuse, counseling and other services may be required as adjuncts or alternatives to separation and divorce.

CHILD ABUSE

One can hypothesize that as more is learned about the variables related to spouse beating, multi-dimensional explanations similar to those being developed in child abuse studies will emerge, requiring multi-dimensional treatment responses.

SEVERE ABUSE

Data do not exist on the extent of violence against elders incurred at the hands of family members or other caretakers. While researchers are beginning to explore this problem area, current literature on violence in the family largely ignores the elderly victim.

Sterns defines the range of abuse to include neglect, physical or emotional abuse to make him/her more manageable, and sexual assault. Sexual abuse may be explained either by lack of understanding of the older person, or as a result of the demographic and personal characteristics of the victim (less able to resist, demanding), or lack of education of the abuser (husband, son, daughter)."

Just as a learned role model, in one of the few controlled studies we know of, Parker and Schumacher found that a "learned role model" may indeed be a relevant factor of these cases. Their study demonstrated that if the abuser was a victim of the battered wife syndrome, there is a statistically significant probability that the wife will be battered by her husband. The study controlled for education level and alcohol by the husband in the variability of abuse. While we can say that that parent will be quite old and perhaps quite frail. Treasure, the third of second generation care givers were experiencing symptoms of excessive anxiety, stress and that 40% had insomnia, headache, depression and anxiety. While we can say that that parent will be quite old and perhaps quite frail. Treasure, the third of second generation care givers were experiencing symptoms of excessive anxiety, stress and that 40% had insomnia, headache, depression and anxiety.

Society's response to the "discovery" of spouse abuse appears to be following a pattern similar to that of child abuse: first the media, then practitioners, social workers, police, and finally, legislation. Legal remedies are being explored while, at the same time, the victim protection from continued physical assault, does require immediate police and court intervention at the request of the victim. Observers in states such as Massachusetts, however, where family courts have been given the power to intervene in cases of violence, have found that each of us may be wearing two hats: one as a wife, the other as a legal remedy in itself may not be an adequate response to spouse abuse, counseling and other services may be required as adjuncts or alternatives to separation and divorce.

Sterns defines the range of abuse to include neglect, physical or emotional abuse to make him/her more manageable, and sexual assault. Sexual abuse may be explained either by lack of understanding of the older person, or as a result of the demographic and personal characteristics of the victim (less able to resist, demanding), or lack of education of the abuser (husband, son, daughter)."
poor health (within the family) may accentuate poor family relations, leading to institutionalization of the at-home parent. She also discusses the concept of a "least restrictive alternative" or a "least intrusive" one, usually for the greatest protection of self-esteem and self-determination, and for the least restrictive alternatives to care, such as emergency housing or foster care, are scarce or non-existent in many communities.

The recognition and identification of abuse of the elderly accomplishes little if no service system exists to address the problem or if institutionalization of the elderly is the only remedy available to the family and practitioner trying to cope with abuse. Will we, having identified the problem, also organize the systems needed to deal with elder abuse cases? And if this response is forthcoming, can we apply what we have learned from child and spouse abuse to the abuse of the elderly?

A series of questions which seem relevant to elder abuse immediately confront the reviewer of child and spouse abuse literature. Each question would make a worthy topic of study:

- What role does stress (ego, loss of job, marital difficulties, illness) play in the abusive situation?
- Do abused elders share any physical, emotional or other traits? Can they be distinguished in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
- What are the experiences of other countries in this area?
- Do abused elders differ in any way from non-abused elders? Do abusers differ from non-abusive persons in some way other than having committed the abusive act?
- What social or cultural norms are society conducive or conducive to violence against elders?
- Does violence against elders cut across cultural and/or national boundaries?
Neglect: "a disabled adult who is either living alone and unable to provide for himself the services which are necessary to maintain his mental and physical health or is not receiving the services from his caretaker."

Abuse: "in individual who has responsibility for the care of the disabled adult as a result of family relationship or who has assumed the responsibility for the care of the disabled adult voluntarily or by contract."

Disabled adult: "any person eighteen years of age or over, who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy, organic brain damage caused by advanced age or other physical degeneration in connection therewith, or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances such as alcohol or drugs."

Abuse: "the occurrence of one or more of the following acts by a parent or other relative of any child under the age of eighteen:"

(a) attempting to cause or causing physical harm
(b) placing another in fear of imminent serious harm
(c) causing another to engage in involuntary sexual relations by force, threat of force or entering into a sexual relationship with a minor

Family or household member: "household member, spouse, former spouse or the parents children or child relative."

Abuse: "non-accidental physical injury(s) to child by parent or other caretaker which results in injury or creates a substantial risk of death, disfigurement, impairment of physical health or loss or impairment of function of any bodily organ or exposing child to substantial risk of serious harm by substance abuse or alcoholism."

Neglect: "failure to thrive, malnutrition, lack of medical care and supervision, injuries or accidents due to inadequate supervision, inadequate food, clothing, shelter, school attendance, dependence upon addictive drug at birth, severe emotional neglect."

Abuse: "inflicted injury, sexual abuse" (two above quotes from Massachusetts General Hospital reporting regulations for child abuse/neglect cases).

Abuse: "inflicted laps or deficits between circumstances of living which would facilitate the optimal development of children, to which they should be entitled, and their actual circumstances, irrespective of the sources or agents of the deficits."

"Elderly Patients inflicted by relative before admission to hospital and in which there has been no doubt that the battering was deliberate."

"Child abuse and neglect means the physical or mental injury, sexual abuse, maltreatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby."

Child abuse: "primarily physical injuries to a child and unlawful acts upon a child. Abuse includes non-accidental physical injuries to a child by parent or other caretaker who acts in the place of the parent if the injury causes a substantial risk of death or disfigurement, impairment of physical health, or loss or impairment of function of any bodily organ. Abuse also means to expose child to substantial risk of such non-accidental physical injuries."

Neglect: "any child who does not receive proper care or supervision from his parent, guardian, custodian or other person acting in his behalf, who is not provided necessary medical care or other remedial care designated by state law, or who lives in an environment injurious to his welfare, or who has been placed for care or adoption in violation of law."

Neglect: "includes but is not limited to, the willful infliction of physical pain, injury or mental anguish, or the willful deprivation of a caretaker of services which are necessary to maintain physical and mental health and does not include the said necessary services from the responsible caretaker."

Abandonment: "the desertion or willful forsaking of an elderly person by a caretaker or the foregoing of duty or the neglect of duties and obligations owed an elderly person by a caretaker or other person."

Neglect: "a person who has the responsibility for the care of an elderly person as a result of family relationship or who has assumed the responsibility for the care of the elderly person voluntarily, by contract or by order of a court of competent jurisdiction."

Violence: "the intentional use of physical force on another person, or another physical stimulus invoked by one person on another. The physical force may be viewed as assaultive, designed to cause pain or injury as an end in itself, or as forceful acts of restraint. Violence may also be characterized as "hostile" or "aggressive" but behind legitimate violence are cultural dimensions that involve the acceptance of violence."

Bibliography


AN ANALYSIS OF PROTECTIVE SERVICE SYSTEMS FOR HANDLING ABUSE CASES

III. SERVICE SYSTEMS ANALYSIS

A. An approach to systems building

Abuse of any person constitutes a serious problem, but abuse of persons sixty and over raises especially difficult questions throughout the community. Police departments, social services agencies, hospital admitting desks and even agencies whose sole focus is the elderly client can be tied in knots by one case of alleged or suspected abuse. Even complaints of abuse supported by eye-witness accounts can be extremely frustrating and time-consuming for the case manager who must deal with other pressing cases.

There are many factors which contribute to the difficulties inherent in managing a case of alleged or actual elder abuse, but two in particular deserve more note. First, more and more frequently, elders are living to a very old age and are being cared for in whole or in part by members of their family. (see Appendix A: A Review of Recent Literature). Initial results of a statewide survey on elder abuse indicate that the very family members upon whom the elderly are dependent for personal, financial, and/or emotional support, are frequently the perpetrators of violence. Thus, when a case worker is faced with an abusive situation (alleged or actual), s/he must be prepared to fill the gaps in services which may result when the family support network is disrupted for a time permanently. This action requires a degree of services coordination which is not available in many areas.

Second, the coordination of community services, ever an easy task in any situation, is made more difficult in instances of alleged or actual abuse because of the complex legal and ethical questions which confront the case worker and because of the possible emergency nature of the case. During the training component of this grant, LISER staff were continually asked by workers with elders how they should proceed in a situation where concern for the safety of the elder client has to be weighed in a matter of hours against the right of that client and his/her family to privacy and self-determination. "Who," they ask, "has the authority or responsibility for intervening in such cases, and how can the necessary community resources be mobilized in such a short time?"

In attempting to address these complex issues, LISER staff have conducted field interviews with persons currently managing elder abuse cases and with national experts; we have conducted literature and statute reviews and, perhaps most importantly, we have examined current approaches to children's protective services in this country.

As detailed in the literature search, family violence, whether husband battering, child battering or battering of elders, is a multi-dimensional problem. Its solution must therefore be multi-dimensional in scope. This means that those who intervene must be able to respond to the social, legal, financial, emotional and medical needs of the abused person. There may also be housing and nutritional deficits which must be addressed. Meeting such needs requires coordination of a variety of service providers as well as developing service alternatives which currently do not exist in most communities. This inter-agency, multi-professional response to elder abuse is crucial to its resolution.

Basically crucial is the need to identify and address the chronic conditions which may have contributed to abuse of the elder. As in child abuse, removing the child from the home until "safe" is accomplished little more than a band-aid which may be complicated by a job placement, medical assistance and other services may be required to create a stable home environment in which violence plays no role. Services which merely address the ills of abuse and not the contributing conditions, may serve to exacerbate existing tensions within an already deteriorating family structure. Services to the abused person's family are as important as services to the victims in any protective service situation.

We should be clear here that we are using the term "family" in a broad context, to include both relatives and other non-related caretakers of an elderly person. Obviously, even in situations where family are not involved, the ability of the service network to address the chronic conditions which permitted abuse to occur is crucial to the well-being of the client and the success of the services system in handling cases.

In the preceding section of this report entitled "Legal Analysis," we have put forth our recommendations for a mandated elder abuse reporting law which, while offering protection to the abused individual, also adheres to the right of that individual to privacy and self-determination. That analysis clearly stresses the need to accompany such legislation with a protective services capacity which can: (1) provide immediate protection to the victim of abuse, (2) coordinate with other protective services and social systems with which the victim may be in contact (see section on "Crime in and around the home"), and (3) provide follow-up data on the nature of abuse which will permit us to refine our responses to this serious problem.

In framing our legal analysis, certain principles were set forth which apply equally well to our model for a protective services system for abused elders. As we describe that model below, these principles (the client's right to self-determination and least restrictive alternatives to care) are implicit.

Two additional principles play an important role in our proposed model for protective services for elders:

1. Maintenance and support of the family support network whenever possible. In many communities, a case of elder abuse may act as a catalyst for the intervention of the victim whenever possible (a derivative of the "least restrictive alternative")

2. A. Model protective services system

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the states can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model, as set forth below, consists of general principles which any community should keep in mind when setting up an adult protective services system which are largely unavailable in most communities. The model provides a basis for assessing the effectiveness of existing networks of care.

B. Model protective services system

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the states can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model, as set forth below, consists of general principles which any community should keep in mind when setting up an adult protective services system which are largely unavailable in most communities. The model provides a basis for assessing the effectiveness of existing networks of care.

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the states can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the states can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the states can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the states can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.
the client who refuses assessment/service delivery and who appears to be mentally competent, it is essential that one person be held accountable for managing a given case. This person, the protective service worker, plays a crucial role in linking community resources to the victim by other intra-agency services providers. 

There are a number of ways to categorize abuse cases and to develop subsequent protocols. The four categories described above seem the most basic; however, since they have as a reference the client's right and ability to determine the system's response to his/her problems. Also, importantly, the issues confronted by these case typologies (the client's capacity for and right to self-determination) are the very ones which will bring the protective services system to a halt and time again unless pre-planned responses are available.

For example, workers attending training sessions held by LIRSE staff spoke of their feelings of helplesslessness and para-sitism when confronted with suspected victims of abuse who refused assessment and services. Concerns over protecting client rights and potential guardianship situations and questions about the proper use of legal representation for clients and other issues confronted by these titles of concern can only be managed by allowing the agencies to have, in writing, a list of steps and time frame which should be followed when clients are confronted with such situations. These steps allow the system to meet both the client and worker from lax or overzealous reactions and help assure the worker remains cognizant of the client's rights.

Communities can understand this development activity now, regardless of the state's administrative or legislative responses to the problem of abuse. LIRSE staff will also begin to develop model protocols as part of their activities under a Title XX Training Grant for workers with abused elders. A brief discussion of the four basic client groupings outlined above is contained in section 6 of this part.

(b) Interdisciplinary response.- Abuse is a multi-dimensional problem whose resolution requires input from many service agencies. Services which are available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders. The protective services committee's role is two-fold:

- To establish linkages between agencies that will permit services coordination to take place in a timely manner, including the development of protocols as described above, and
- To provide an ongoing review mechanism for individual cases.

In some communities this dual function might be played by a single interdisciplinary committee; in others, two groups (agency directors; case managers; case workers) may be more logical. These functions might also be performed by a team from one agency assigned by the community to handle cases of elder abuse and having its own internal staff capacity to provide a full range of core services.

Core services in a protective services system.-While the services required by individual clients differ, a protective services network for elders should be able to provide a basic group of core services, many of which can be provided by the team described above in section 1. These core services include arranging for arranging more long term alternatives. It is essential that legal counsel for the elder be arranged immediately in order to protect the due process/fair hearing rights of the individual. Legal services may be obtained from legal services offices and elderly law projects, lawyers' guilds and private attorneys.

(5) Homemaker/home health aide services.-These services are available through Home Care Corporations and local housing programs, community health agencies, and private charitable organizations.

(6) Financial assistance.-In cases of elder abuse, the victim may be dependent upon the abuser for support, an arrangement which can be temporarily or permanently disrupted. It is important therefore for the protective services system to have some catch-on-hand or other source for assisting the client in times of immediate crisis and for arranging more long term alternatives. Private or public charitable agencies may be available to assist the client in times of immediate crisis and for arranging more long term alternatives. Private or public charitable agencies may be available to assist the client in times of immediate crisis and for arranging more long term alternatives.

(7) Interdisciplinary response.- Abuse is a multi-dimensional problem whose resolution requires input from many service agencies. Services which are available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders. The protective services committee's role is two-fold:

- To establish linkages between agencies that will permit services coordination to take place in a timely manner, including the development of protocols as described above, and
- To provide an ongoing review mechanism for individual cases.

In some communities this dual function might be played by a single interdisciplinary committee; in others, two groups (agency directors; case managers; case workers) may be more logical. These functions might also be performed by a team from one agency assigned by the community to handle cases of elder abuse and having its own internal staff capacity to provide a full range of core services.

Core services in a protective services system.-While the services required by individual clients differ, a protective services network for elders should be able to provide a basic group of core services, many of which can be provided by the team described above in section 1. These core services include arranging for arranging more long term alternatives. It is essential that legal counsel for the elder be arranged immediately in order to protect the due process/fair hearing rights of the individual. Legal services may be obtained from legal services offices and elderly law projects, lawyers' guilds and private attorneys.

(5) Homemaker/home health aide services.-These services are available through Home Care Corporations and public and private homemakers/home health aide agencies.

(6) Financial assistance.-In cases of elder abuse, the victim may be dependent upon the abuser for support, an arrangement which can be temporarily or permanently disrupted. It is important therefore for the protective services system to have some catch-on-hand or other source for assisting the client in times of immediate crisis and for arranging more long term alternatives. Private or public charitable agencies may be available to assist the client in times of immediate crisis and for arranging more long term alternatives.

(7) Interdisciplinary response.- Abuse is a multi-dimensional problem whose resolution requires input from many service agencies. Services which are available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders. The protective services committee's role is two-fold:

- To establish linkages between agencies that will permit services coordination to take place in a timely manner, including the development of protocols as described above, and
- To provide an ongoing review mechanism for individual cases.

In some communities this dual function might be played by a single interdisciplinary committee; in others, two groups (agency directors; case managers; case workers) may be more logical. These functions might also be performed by a team from one agency assigned by the community to handle cases of elder abuse and having its own internal staff capacity to provide a full range of core services.

Core services in a protective services system.-While the services required by individual clients differ, a protective services network for elders should be able to provide a basic group of core services, many of which can be provided by the team described above in section 1. These core services include arranging for arranging more long term alternatives. It is essential that legal counsel for the elder be arranged immediately in order to protect the due process/fair hearing rights of the individual. Legal services may be obtained from legal services offices and elderly law projects, lawyers' guilds and private attorneys.
belief it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.

The elements of a statewide adult protective services system should be uniform, however, and are discussed below. Communities should not be deterred from start-up activities because such uniformity does not currently exist, however.

(a) Standardized record-keeping.-The protective services system will be improved by standardized record-keeping which permits audits for service and client characteristics. Records should reflect service goals as well as casework process and should be kept by client number so that confidentiality can be maintained during case reviews. Uniform record-keeping creates both a data-gathering capacity for planning purposes and a case review capacity which would promote (if not enforce) timely handling of cases, systematic reviews of individual client progress and adequate fair hearing and grievance procedures for clients and providers. A national or state report based upon this information should be prepared by the designated state agency.

(b) Emergency services.-It is essential to be able to organize protective services for victims of elder abuse for a national or state-wide effort is needed to assure service availability in all areas.

(1) Emergency shelter/housing.-This constitutes perhaps the single most important gap in services to victims of abuse. Widespread access to shelter for abused elders is often the first step in breaking the cycle of abuse. With increasing numbers of communities able to organize protective systems and to assure their availability to victims of abuse, the need continually grows.

(2) Medical—legal services (for advice or representation of the client).

(3) Emergency funds; and

(4) Emergency medical care (in the home or by ambulance if necessary).

(c) Crisis intervention.-The crisis intervention response must be uniformly organized and available to all eligible clients, including the abused and non-abused. The potential benefits and impact on the design of the services delivery system and the total cost of the process are tremendous.

(d) Uniform system of case finding, reporting, and referral.-While it is not essential that a single agency be designated in each area for receiving reports of elder abuse, or that that agency be identical across all areas of the Commonwealth, it is important that this responsibility be clearly stipulated in each area or community of services. A network of sources, such as visiting nurse associations or hospitals, could be designated to perform this function and to be responsible for subsequent referral to other community organizations. While Home Care Corporations might be logical choices in some communities, DRA is recognized and utilized in other states. Public agencies such as social services, courts, police, and the regulators of various professions may be designated as those responsible for the initial referral process. The decision of which agency is designated in each area or community, its responsibility should be the receipt of abuse reports, assignment of an assessment team to investigate, service delivery planning, and the handling of cases. Such a system should be organized for all communities and should not be discontinued.

(e) Uniform eligibility guidelines.-State mandates for adult protective services, or to confine legislation to the protection of abused elders, is a logical choice in some communities. DEA is essential that this responsibility be clearly pinpointed in each area or community. DEA should be designated in each area or community, its responsibility should be the receipt of abuse reports, assignment of an assessment team to investigate service delivery planning, and the handling of cases. Such a system should be organized for all communities and should not be discontinued.

(f) Uniformity.-The ability of this system to be uniform across areas and communities is obviously an important one since this ability to deal with cases of elder abuse. While some states are organized under the social services approach described herein does not assume the

(g) Uniformity of services.-The model protective services approach described herein does not assume the passage of a mandated elder abuse reporting law or the designation of a single state agency responsible for handling abuse cases. While we obviously support these concepts, we also believe it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.

(h) Uniformity of services.-The model protective services approach described herein does not assume the passage of a mandated elder abuse reporting law or the designation of a single state agency responsible for handling abuse cases. While we obviously support these concepts, we also believe it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.

(i) Uniformity of services.-The model protective services approach described herein does not assume the passage of a mandated elder abuse reporting law or the designation of a single state agency responsible for handling abuse cases. While we obviously support these concepts, we also believe it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.

(j) Uniformity of services.-The model protective services approach described herein does not assume the passage of a mandated elder abuse reporting law or the designation of a single state agency responsible for handling abuse cases. While we obviously support these concepts, we also believe it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.
Inability of some abused persons to consent to services or to even acknowledge their victimization may be all that is necessary to re-establish a harmonious family unit. A wise and caring worker can, over time, bring the victim and caretaker to this realization and arrange for service delivery. The worker's initial objective in such a case is to keep lines of communication open with the client and caretaker so that eventual problems resolution is possible.

In another case, however, of repeated and malicious violence against an elder by a son whose violent nature has already been demonstrated, the worker may very well have to confront the victim with the continuing danger of his/her situation and the need to take legal action against the abuser. The elder may, in that case, very well ask the worker to leave.

Despite the worker's frustrations in this situation, a home must recognize that the client has a right to refuse services. Again, the worker should strive to keep communications links open with the client and family and may wish to work with other service providers already involved with the family in strengthening the family and clients existing support network. Issues of confidentiality are particularly difficult in this type of case and should be closely examined as the protective service system is being designed. The degree to which the worker will "walk away" from a non-consenting client or develop alternatives which do not violate the client's right to privacy and self-determination, could be the single most difficult moral issue which the protective service system and workers will have to face.

C. FUTURE CLIENT TYPOLOGIES

The JABSE survey on elder abuse has demonstrated that abuse comes in many forms, from maltreatment to withholding of needed medicines to physical assault. The services which are required to address the immediate and more long-term problems of the abused person and his/her family will vary from case to case.

Regardless of this variation in service need, abuse cases, and adult or elder abuse in particular, present certain common hurdles for service providers. These problems have to do with the unwillingness and/or inability of some abused persons to consent to services or to acknowledge the existence (or potential existence) of abuse.

Individual workers and the protective services system as a whole must be prepared for this eventuality, for it will occur and probably quite often. Difficult legal and ethical considerations must be faced when the client is a non-consenting adult; we have also found that the worker's own feelings and frustrations must be confronted and dealt with in these cases.

While we are not prepared at this time to present a definitive set of guidelines for handling such cases, we have begun this task by identifying four basic client typologies which protective services workers for elders will encounter.

1. The consenting client who appears to be mentally competent.—This is perhaps the most straightforward type of case where protective service workers will encounter. Based upon our discussions with existing protective service workers and abusing great-traited abused cases, it may also be the most frequent occurrence. In this situation, the worker is confronted with a client (the victim) who, regardless of his/her willingness to admit that abuse has occurred, is willing to be assessed for service delivery and to receive necessary services. The client may also be willing (and eager) to deal with the problem and participate in the long-term resolution of that problem. This resolution may include legal action as well as social service delivery.

In such cases, the worker's role includes arranging for assessment, developing a service plan (in conjunction with the client and family), working with the client's family to address the problem, and, if necessary, coordinating efforts with the client's attorney or providers in order to receive the client in obtaining legal services.

Issues that arise in this type of case may include disagreements over case planning between the client and worker and possibly among the agencies or service providers involved in handling the case. The worker's role is in this type of case may also be problematic, especially if the worker's attitude toward abuse (real or alleged) is unconsoling-client who appears to be mentally competent.—Very different issues are confronted when the client (alleged abuse victim) refuses to see the assessment worker or to accept services, or is too frightened or too ambivalent to alert the worker admittance to his/her home or to access victim. This presents the worker with an immediate access problem. The worker must take steps to obtain legal authority to enter the home of an alleged victim of abuse.

Under such authority be given through abuse legislation, workers will still be faced with potentially hostile households and with elders who fear victimization and fear being left alone. The worker's initial approach to the family and elder may help to set the tone for future discussions and may increase the worker's access to the victim. Workers should not be driven by a desire to "punish" the abuser or to effect confessions of abuse from either the victim or abuser. The worker's goal, instead, is to attempt to assure the safety of the victim and to address the problems which may have led to the abuse act(s).
The following is an evaluation of the protective services capacities of the three project sites which were selected to participate in the DRA-LHSS Elderly Abuse Grant and which have taken some steps to organize a protective services system for elderly clients. The evaluation presented below does not constitute a judgment of the ability or desire of individuals or agencies to participate in a protective services system for elders, but rather outlines the following systems and describes the protectiveness of the services model described in section B of this report. This model includes the following characteristics.

I. General Systems Characteristics
A. Pre-planned case responses (protocols)
B. Interdisciplinary response

II. Case Services in a Protective Services System
A. Protective service worker
B. Case assessment team or worker
C. Primary health care services
D. Legal services
E. Homemaker/Home health aide services
F. Transportation
G. Nutrition
H. Financial assistance
I. Police—no access, ambulance or imminent danger
J. Emergency services
K. Follow-up

III. Additional supportive services
A. Emergency shelter/housing
B. Counseling groups for abused and abuser
C. Foster care for children
D. Day care or recreational activity centers

IV. Statewide or uniform service system characteristics
A. Standardized record keeping
B. Uniform eligibility guidelines
C. Uniform system of casing, finding, and referral
D. Confidentiality guidelines
E. Training
F. Funding

Because highly specific demographics are available through the Title XX Unit of the Massachusetts Department of Public Welfare (cf.: Regional and Area Projects: January, 1979) and through the Executive Office of Human Services (cf.: Resource Inventory Project 1978), much of the data contained in this section is derived from extensive interviews with staff assigned to Home Care Corporation's target communities, the three project sites.

Worcester and Boston III. Each is unique to its area. Two are formal; one is informal. None meets the goal of a comprehensive protective services system and none has any statutory guarantee of its existence beyond a given funding cycle.

Merrimack Valley

Description
Merrimack Valley accounts for the second largest population concentration in the Valley. Although twenty-four cities and towns comprise the homecare corporation's target communities, the three most populous cities, Lowell, Lawrence, and Haverhill, provide the agency bases for the protective services delivery system.

1. Funding
The Merrimack Valley protective services network had available to it for the first eight months of the fiscal year between 1 September 1978 and 31 May 1979 a sum of $28,000. $21,000 (or 75% of the eight month total) was generated by a Title III grant under the Older Americans Act. The remaining $7,000 of "in-kind" monies came from the greater agencies: Family Service of Greater Lawrence, Family Services of Greater Lowell and Children and Family Aid Society of Haverhill. Twelve month funding should maintain the fixed 75%--25% ratio designated of Title III grants. Thus, on an annualized basis, the inter-agency network expects $32,500 from Title III with an expected "in-kind" match of $5,000.

Funds contained in the Merrimack Valley proposal were almost entirely applied to salaries for three staff persons. Only $600 has been set aside for emergency services. According to one agency director in the consortium, that sum may soon be "carefully watched over and only touched in dire emergencies." One interesting sidelight of that approach is that the network ended its first year with a balance in the emergency funds account.

Auxiliary to the grant which funded the Merrimack Valley protective services mechanism was a second Title III grant used to hire, train and supervise "protective services homemakers." This will be discussed in greater detail under the staffing portion of this report.

2. Location
The Merrimack Valley area's location may well be one of its most innovative points. Situated at the urging of the local Home Care Area on Aging, Elder Services of the Merrimack Valley, Inc., the grant links three family service associations in Lawrence, Lowell and Haverhill. In addition, case management and supervisory staff from the home care corporation have involvement. Not only does the network geographically reach out into the Valley, it capitalizes upon the unique experience of each of the consortium members. This approach to delivery and decision making insures that the means of coordination of services participants choose to use them. Further, accountability is now targeted among the three MSW social workers assigned to each agency. These workers, in turn, are responsible for linking clients with the network of services available in the Valley including referral and follow-up for all of the services described in our model system.

3. Staffing
The protective services network in Merrimack Valley employs three half-time MSW level social workers. One worker is stationed in each of the family service agencies. In addition to their half-time protective services work, workers are assigned to Home Care Corporation and other social service providers located in the initial five project sites. These five sites, Worcester, Mystic Valley HCC, Minuteman HOC, Merrimack Valley HOC and Boston Area III HOC represent a moderately definitive cross section of the existing approaches to elderly protective services in Massachusetts.

Of the five sites, two (Worcester and Mystic Valley) have ongoing protective services delivery mechanisms. Minuteman HOC plans to add a protective services component shortly, while Mystic Valley currently has no staff person or unit targeted for responsibility with regard to protective services and balance, none to drive an interdisciplinary team. Since this nurse splits her time between these two sites of six to seven homemakers and their clients and a local community mental health center, the protective service network not only has access to the expertise of well-supervised specialty homemakers, but there is a direct link with the mental health counselor as well. This kind of service stretching is not unusual in other areas of human services and should be encouraged in the elderly services network as well.
No special mechanisms exist for protective services referrals to the three consortium members. Cases do not all come before the consortium sitting as a protective services committee. (Committee meetings are held approximately every two weeks.) Those cases which cannot routinely be handled by a member agency through its own services network appear before the committee after acting as a PHRO (Professional Staff Review Organization). Confidentiality is maintained at all times and potential recipients of protective services are "staffed" or "cased" as they might be in a community mental health center or in a health services setting such as a hospital or mental health maintenance organization. This approach has the same essential value for protective services that it does for any of the service systems where it is already widely used. Not only is group expertise brought to bear on the solution of casework problems, but the group also acts as a self-criticism unit and as a place where common service needs can be discussed and pursued.

Observed during a self-evaluative session in March 1979, committee members agreed that little outreach had been organized around protective services, and that it had largely been limited to the major population centers. Since there is no separate protective services casework capacity in the area, the question is, it is understandable that the principles might be reluctant to adver-
tise something already used to its maximum. If this is true of casework capacity, it may certainly be true of some of those same oddballs for other services such as homemaking, nutrition, home nursing, etc. Service possibilities also cluster in Lawrence and Lowell rather than in Dracut or Tyngsborough. The unevenness of service availability would no doubt present a problem if outreach were stepped up.

5. Services

The Merrimack Valley protective services network currently has the capacity to provide quick, on-going casework services to consenting clients. Ancillary and support services such as homemaking can be arranged through links to the home care corporation or other members of the service community. Services are intense and coordinated; however, they are dependent upon the referellant re-
questing the provision of services. Since many of the victims of abuse cited in the 1979 LRE survey had refused services within the past eighteen months, this ratification of the client pool to those who request services is considerable.

6. Statistical Information

In the period 1 March 1978 through 28 February 1979, the Merrimack Valley protective services network provided services to eighty-one individuals. Of these, eighty-one individuals, it is estimated that between twenty-five per cent and thirty per cent met the LRESE definition for an abuse pool. Protective services cases tend to be low because of the intense and acute character of the intervention strategies required. Workers carried between five and ten cases at any given time. Intervention strategies favored least restrictive alternatives and involvement heavily upon home care corporation involvement. Authorizations for service were considerably larger than the protective caseload than among other caseloads.

The Merrimack Valley approach to protective services seems to utilizes most (if not all) the service opportunities available within the twenty-four community

which make up the region and to embrace the principles set forth in the LRESE model system. Further, as demonstrated by the protective services home-
care component, the network has the ability to assess need and to de-
velop innovative resources. This is quite obviously an interdisciplinary approach to adult protective services.

Despite these positive factors and despite a well-trained staff willing to serve the needs of her clients, funding limits the effort to a different extent. The incentive to advertise the service outside the participating agencies because there is no capacity to grow. Important support services available such as homemaking, nutrition, home nursing, etc. Service possibilities also cluster in Lawrence and Lowell rather than in Dracut or Tyngsborough. The unevenness of service availability would no doubt present a problem if outreach were stepped up.

This system needs to be encouraged to extend itself to include police, legal, medical, and medical providers in a more direct way and to systematize its interdisciplinary case review mechanisms to include protocols for emergency intervention. Focusing with a wider range of clients, (e.g., the non-

the necessity for conducting outreach, is small when the long-term nature of the problem is in doubt.

4. Case planning and referral

With the exception of Boston, Worcester is one of the most densely pop-
ulated regions in the state. Elder Home Care Services of Worcester, Inc., the Worcester home care corporation, serves not only the urban area, but fours surrounding communities as well, including some rural parts of central Massachusetts. The presence of a teaching hospital and several outstanding universities and research facilities adds considerably to the service and skills base available to area residents.

Elder Home Care decided to develop a protective services capacity after completing a needs assessment of its own caseload. A review of community resources indicated an unmet need for emergency protective services. While the network also has provided protective services, these are all United of the Department of Public Welfare. None of the three Title XX grants has the capacity to make in-home assessments, nor are they formally linked to the Elder Home Care. Planning staff from United Way of Worcester and from Elder Home Care met on an informal basis to minimize duplication of service.

1. Funding

Elder Home Care has access to an $16,000 grant from Title III of the Older Americans Act. "That just about pays the salary of the worker and the fringe," It is necessary for the salary figure, protective services includes an additional $1,000 for client emergencies drawn from another budget. There was no figure available for the cost of worker supervision and back-up.

2. Location

The protective services worker maintains her office at Elder Home Care, Inc. If a client is not home, however, takes place on site in clients' houses. In addi-
tion to the worker's regular Home Care office and representatives from the Visiting Nurse Association and from Central Massachusetts Legal Services. Similar to the sys-

ten is in use in the Merrimack Valley, this committee not only provides a form of all staff goes in rotation. This committee is, for example, beginning to address the issue of providing some information about mandated mental health services for autistic populations which may prove useful in a proposed collabora-

3. Staffing

The protective services worker is an MSW social worker. She is supervised and her services are backed up by another MSW social worker. The protective services worker herself provides not only direct services to protective clients, but acts as a resource to case management staff as well.

4. Case planning and referral

Since the protective system is located within the home care corporation, the referral mechanisms is usually a direct and internal one. Referrals also are (those which are "home grown") are handled by the protective services committee in a useful referral council. These are at least a few of the problems which arise in terms of guardianships and conservatorships. Similarly, the police, often the first people contacted in an elder emergency, have access to a useful service resource.
5. Services

The Elder Home Care protective services component can provide a nearly comprehensive package of protective services. This includes not only emergency, in-home assessment, but crisis counseling by a trained professional as well. Because of its location in a home care corporation, the protective services unit can draw upon homemaking, health aide or chore services in a speedy and efficient manner. Emergency funds assure that nutritional and housing emergencies can be met on a short term basis. Emergency relief care in a nursing home has been investigated and may ultimately join the services available for protective clients. As mentioned above, probate court problems arising from surrogate authority needs can be partially assisted through a link with the clerk/court's office. Support services such as transportation are available to protective clients as they are available to all clients of the home care corporation.

6. Statistical information

In the past year, Elder Home Care's protective services component has provided service to ninety clients. Of these, sixty-five were female and twenty-four were male. Although the greatest number of clients clustered in the age range seventy-five to eighty-four, four protective services clients were over ninety-five. There were no figures available for number of possible abuse cases though the worker indicated that perhaps ten to fifteen per cent of her caseload were possible abuse victims. One worker noted that for him the issue was not the difference between abuse and neglect but rather how many clients were high risk. It is possible to begin tracking protective clients and their specific service needs and thus do one of the best assists to planning for future staffing. As in the Mattapan, though, that these high risk clients are in chronic stress situations and enter the protective category during times of acute episodes.

Elder Home Care presents one of the more streamlined approaches to protective services. The use of a community based, interdisciplinary protective services committee aids considerably to the product which the home care corporation is able to deliver. Staffing is professional and costs have been kept relatively low. Even though not located in a social work agency, the protective component is professional social work supervision and backup services.

These protective services operation might be enhanced if it could establish some kind of inter-agency agreement about specific mental health evaluations with or through the geriatric team of the community mental health center serving that catchment area. Ultimately, this kind of inter-agency cooperation might make it possible to begin tracking protective clients and their specific service needs more carefully. Since the protective caseload, even if treated as a series of acute episodes in otherwise chronically troubled lives, will only grow, some thought should be given to growth. Establishing a staff of protective workers and protective staff only at the supervisory level. (Note: as may be seen in the services section which follows, those decisions about staffing have influences in other service related areas.)

In addition to these two major grants for protective services, there is a variety of other more specific protective services available through the Visiting Nurse Association, the Boston Elderly Legal Services, Massachusetts Legal Assistance Corporation. There is no question that these high risk clients are in chronic stress situations and enter the protective category during times of acute episodes.

Elder Home Care protective services component located within that agency itself. It has a trained professional as well. Although protective staff are restricted by community. There are various other "protective services" resources through agencies as diverse as the Eastern Home Care Corporation and the Mattapan, protective grant for elders, treats its clients to enhanced by the use of computer driven analyses of clients and a variety of other more protective services. As in the case of Protective Services, the philosophy is traditional, casework oriented and is organized and state seed monies are probably necessary to spur the development of important emergency shelters for elders.

Boston Arron III

Description

Social Services Home Care Services, Boston III, Inc. includes nine inner city communities: Charlestown, Beacon Hill, Mattapan, East Boston, West End, South Cove, South Boston, Dorchester and North End. Although Boston III Home Care services most of the city's most diverse and crime-prone areas, it has a protective services component located within that agency itself. Major protective services grants have been located at Family Services, Inc. ($200,000) and at the Council of Elders ($450,000). Both these grants represent grants from the Department of Public Welfare's Purchase of Service Unit (Title XX) and neither has any formal link to the Department of Elder Affairs nor is it an agency in the home care corporations in the targeted community. Funds contributed to these funds (which are restricted by community), there are various other "protective services" resources through agencies as diverse as the Eastern Home Care Corporation and the Mattapan, protective grant for elders, treats its clients to enhanced by the use of computer driven analyses of clients.

There are few (if any) service deficiencies in Boston III in the usual sense of that concept. Coordination of existing services constitutes a far greater problem in Boston than does any specific lack of services. This section will attempt to examine some of what is available. Remarkable as it may seem, no single agency has a full listing of resources available in Arron III. Information is exchanged orally and informally. Since few workers have an adequate grasp of what is available to them, it is too hard to imagine the set of resources available to older persons in Boston III. Elder Home Care protective services component located within that agency itself. It has a trained professional as well. Although protective staff are restricted by community. There are various other "protective services" resources through agencies as diverse as the Eastern Home Care Corporation and the Mattapan, protective grant for elders, treats its clients to enhanced by the use of computer driven analyses of clients and a variety of other more protective services. As in the case of Protective Services, the philosophy is traditional, casework oriented and is organized and state seed monies are probably necessary to spur the development of important emergency shelters for elders.

1. Staffing

Stafing of adult protective services units varies widely. The Family Services Association of Greater Boston uses a combination of graduate trained social workers and undergraduate level "social service technicians." All supervision is provided by MSW's. The Council of Elders, on the other hand, has graduate trained staff only at the supervisory level. (Note: as may be seen in the services section which follows, those decisions about staffing have influences in other service related areas.)

In addition to these two major grants for protective services, there is a variety of other more specific protective services available through the Visiting Nurse Association, the Boston Elderly Legal Services, Massachusetts Legal Assistance Corporation. There is no question that these high risk clients are in chronic stress situations and enter the protective category during times of acute episodes.

Elder Home Care protective services component located within that agency itself. It has a trained professional as well. Although protective staff are restricted by community. There are various other "protective services" resources through agencies as diverse as the Eastern Home Care Corporation and the Mattapan, protective grant for elders, treats its clients to enhanced by the use of computer driven analyses of clients and a variety of other more protective services. As in the case of Protective Services, the philosophy is traditional, casework oriented and is organized and state seed monies are probably necessary to spur the development of important emergency shelters for elders.

2. Case planning and referral

Referrals originate and terminate in almost every combination and permutation of agencies and individuals. For intra-agency referrals there is little (if any) predictable follow-up. For example, the local legal services office for older persons refers clients in potentially abuse/exploitative circumstances to a protective services unit unless the client is willing to pursue a legal remedy. Most are not ready initially and the referral to a social services provider is appropriate; however, there is no mechanism—other than the older person him/herself—which insures that this interface will be accomplished. There is, of course, no way of knowing how many clients treated in this way actually complete the referral. Most probably do. Inter-agency referrals probably constitute the single most vulnerable point in an agency-client relationship in Boston III.

3. Services

Service for Older Persons (SOP), the Family Services Association's adult protective grant helps to treat three classes of clients to a form of inter-agency cooperation might make it possible to begin tracking protective clients and their specific service needs more carefully. Since the protective caseload, even if treated as a series of acute episodes in otherwise chronically troubled lives, will only grow, some thought should be given to growth. Establishing a staff of protective workers and protective staff only at the supervisory level. (Note: as may be seen in the services section which follows, those decisions about staffing have influences in other service related areas.)

The Council of Elders Evaluation Services Program (ESP), the smaller service provider in terms of geographic area covered, uses a more focused approach to protective services. While the grant is clearly titled "adult home care", its operation as a whole more accurately resembles a general protective services program. Although clients tend to remain within the system longer than those in the SOP caseload and it is not uncommon for the worker to become known as a general protective agency. There is no money set aside for specific protective services, though the agency does participate in the Boston Area Home Care Corporation. Like SOP, the Council's protective services unit depends upon both referrals for needs in areas other than those covered by the agency itself. The Council's protective services unit depends upon both referrals for needs in areas other than those covered by the agency itself. The Council's protective services unit depends upon both referrals for needs in areas other than those covered by the agency itself. The Council's protective services unit depends upon both referrals for needs in areas other than those covered by the agency itself.
Evaluation

While vastly more sums of money are available in the Boston III area (and presumably more skills and problems too!) there is virtually no coordination of services of the sort which characterizes either Merrimack Valley's approach or that of the Worcester protective services committee. Virtually all individuals interviewed agreed that the lack of a "system" constituted an ongoing job frustration. Small, but important portions of the service network are being coordinated, however. The OAP supervisor at Family Services Association of Greater Boston needs on a more or less regular basis with service providers in her area, for example; however, she represents (as in Merrimack Valley) a private sub-contractor with no formal link into the Department of Elder Affairs. The Department of Public Welfare does not require any indication of coordination of services delivery as a criterion of its adult protection grants, so there is no formal impetus to do so. While such compulsion could come from the DPW's Purchase of Services contract monitors, that too may not happen.

While urban areas are notoriously difficult places in which to coordinate services, successes such as St. Paul/Minneapolis (Hennepin County) argue for attempting the coordination. If coordination does ultimately prove impossible (for whatever combination of reasons), then a free-standing protective services unit may be the only solution for abused elders in the Greater Boston environs. Depending upon the variable impediment coordination, such an approach might be cheaper in the long run. Certainly the Department of Elder Affairs and the Department of Public Welfare should consider the possibilities opened through issuing joint RFP's in the area of protective services.

Productive systems service models are available outside Boston. The question remaining in whether these models can be replicated in so diverse an area. Certainly, a less than a first step, in Boston III, what appears to be needed is a clearly agreed upon mandate for one agency to take the lead in organizing a systems response to abuse, in order that one or more of these models can be instituted in whole or in part.

1. Statistical information

There is no uniform system of record keeping in Area III's protective grants. While aggregate totals are available, it is not possible to determine (in all cases) which were cases of abuse, or even whether the referrals originated in Area III. Service for Older Persons lists a very low 1 percent category for abuse cases and prefers to call these "high risk" clients. They do not know, however, how many of those clients at risk fall into the Area III catchment. ESP serves only a small area of Home Care III and does not keep records by home care origin, but rather, by geographic boundaries which are not necessarily co-terminus with those set by DIA. (This is not surprising since the ESP grant was originally set to follow Welfare Services Office lines.) The lack of even rudimentary data about abuse cases in Area III points out the need for some agreement across agency lines about case reporting and case recording.

Reporting and Handling

A. Legal recommendations

These recommendations are designed to provide a framework for an abuse reporting law and adult protective services law. They have been drafted by staff members of Legal Research and Services for the Elderly. While accepting the basic principle that society has an obligation and duty to provide protection and care for particular persons who are victims of abuse, neglect, exploitation or abandonment, the recommendations reflect our concern with the rights of the individual to self-determination and due process of law.

Substantive elements recommended to be included in a State protective services and abuse reporting law:

1. The law should apply to persons sixty and older who are abused, neglected, exploited or abandoned and to persons eighteen and older who lack the physical or mental capacity to care for their basic needs and/or protect themselves.

2. Abuse includes, but is not limited to, the willful infliction of physical pain, injury or mental anguish, or the willful deprivation by a caretaker of services which are necessary to maintain physical or mental health.

Neglect refers to an elderly or incapacitated person who is either living alone and not able to provide for him/herself the services which are necessary to maintain physical and mental health or is not receiving the said necessary services from the responsible caregiver.

Exploitation refers to the act or process of taking advantage of an elderly or incapacitated person by another person or caretaker whether for monetary, personal or other benefit, profit or gain.

Abandonment refers to the desertion or willful forsaking of an elderly or incapacitated person by a caretaker or the foregoing of duties or the wilful or neglect of duties and obligations owed an elderly or incapacitated person by a caretaker or other person.

All other terms used should be clearly defined in the statute.

3. One state agency should be responsible for developing an adult protective services program for all citizens. This designated agency or department shall provide services to persons covered by this statute.

4. A report should be required to be made by certain categories of persons including physicians, nurses, social workers, coroners, medical examiners, dentists, hospital staff, nursing home staff, home health agency (staff and home makers), clergy, adult foster care facility, police officers, pharmacists, etc.

Anyone of the above categories who has reasonable cause to believe or suspect that an elderly or incapacitated person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such treatment shall make a report to the appropriate agency within twenty-four hours.

5. Anyone else who has "reasonable cause to believe or suspect" may report this information to the appropriate agency.

6. The identity of the reporting person should be confidential and be disclosed only with the consent of that person or by judicial process. A person acting in good faith who makes a report shall be immune from civil and criminal liability.

7. A person required to report but who fails to do so should be liable for a fine of $500 to $1,000.

8. One state agency should be responsible for receiving and investigating all reports. Each report received should be registered by the agency with all available information from the reporter.

The agency chosen to receive and investigate reports should have a system and personnel to: receive reports 7 days a week, 24 hours a day; keep records; have knowledge of services available; have access to services; have a state-wide mandate; and have the ability and staff (trained) to respond quickly.
A centralized intake system should be geared into a regional response system if possible. The investigating agency should also either provide services or co-ordinate service provision by subcontracting and referral. This should be determined according to existing state service systems.

9. The initial investigation should be conducted by persons trained in human services.

10. Upon receiving a report made in accord with the law, the agency should commence an investigation. This investigation should include a home visit and consultation with service agencies, and persons with knowledge of the case, (including the reporter for further information if possible and necessary). The initial investigation for verification and assessment should be completed within 72 hours. The investigator should have access to a multidisciplinary geriatric team for consultation.

(a) If the report is not verified, the case is closed.

(b) If the report is verified, an assessment of the individual's functional capacity, the situation and the resources available to the person should be made by a multidisciplinary team with expertise in the particular area of disability.

11. In conducting the investigation, the agency may seek the assistance of law enforcement officials and the courts. If access is denied to the investigator, either by the elderly or incapacitated person or a caretaker, the agency may petition for and obtain, in order to ensure intervention with access to investigations. Such shall be issued upon specific facts shown that (1) there is reasonable cause to suspect that the person in question is or has been abused, neglected, exploited or abandoned; and (2) access has been denied to the representatives of the agency required to investigate such reports.

12. Regulations should be promulgated which assure continuity of case management for investigation, assessment, case plan development and service provision.

13. Voluntary services shall be provided upon consent of the elderly or incapacitated individual.

The plan developed shall provide for the least restrictive alternative, client self-determination, and continuity of care. A fair hearing procedure should be developed and implemented so that any service department/agency should be able to provide temporary services as authorized by the court.

14. The department/agency should establish by regulation a sliding fee scale to be used in determining fees for services provided on a voluntary basis. The department should maximize all available financial reimbursement for such services. There should be no charge to the individual in question during the period of the investigation, assessment, etc. These costs are to be borne by the state.

15. If the adult refuses services or withdraws consent, the agency must terminate investigation. This is consistent with the right of the adult to refuse treatment. The case is closed unless the department seeks to provide service pursuant to involuntary provision procedures.

16. Standards of non-emergency involuntary intervention and services provision must include the following:

(a) assessment of need and eligibility; adult refuses services; lacks capacity to consent; no one else can/will consent (See Sec. 22).

(b) clear and convincing evidence.

17. Regulations should be promulgated which assure continuity of case management for investigation, assessment, case plan development and service provision.

18. The department/agency should establish by regulation a sliding fee scale to be used in determining fees for services provided on a voluntary basis. The department should maximize all available financial reimbursement for such services. There should be no charge to the individual in question during the period of the investigation, assessment, etc. These costs are to be borne by the state.

19. If the adult refuses services or withdraws consent, the agency must terminate investigation. This is consistent with the right of the adult to refuse treatment. The case is closed unless the department seeks to provide service pursuant to involuntary provision procedures.

20. Standards of non-emergency involuntary intervention and services provision must include the following:

(a) assessment of need and eligibility; adult refuses services; lacks capacity to consent; no one else can/will consent (See Sec. 22).

(b) clear and convincing evidence.

(c) least restrictive alternative; non-institutional placement where possible.

21. A geriatric/clinical assessment by social worker, physician, mental health practitioner, lawyer to assure appropriate case plan and placement should be required prior to any court order.

22. Placement shall not be in a mental institution, nor will any limitations be required prior to any court order.

23. Any involuntary service provision or placement shall only be authorized pursuant to a court order after a hearing on the merits.

The adult in question shall be assured the right to counsel; if s/he is indigent, the court shall appoint counsel. The adult shall also have the right to be present and to cross-examine the parties involved. If counsel is waived, the court shall appoint counsel and allow to sit in the interests of the court.

24. Adequate notice should be assured. At least 14 days prior to the hearing the court should order served upon the person and any interested party a copy of the petition and notices including an explanation of the proceedings, the date, time and location; the proposed service plan; and the rights of the adult in question at said hearing to consent, to be present, etc.

25. The court order for any protective placement must be specific as to services, treatment, placement approved.

26. Regulation should be promulgated which assure continuity of case management for investigation, assessment, case plan development and service provision.

27. The determination of "lacks the capacity to consent" should be made according to the following:

(a) The adult bases decisions on delusions or hallucinations, is unable to make or implement decisions, or is unable to comprehend a decision's effect.

(b) Hospitalization or change of residence shall not be included unless specifically ordered by the court upon a finding that such action is necessary.

(c) Emergency intervention should be required upon the presence of emergency conditions or necessity to remove the person lacks capacity to consent.

28. Involuntary services should be borne by the state unless a court, after a hearing, orders the client to pay for the services.

29. Standards of emergency involuntary intervention and service provision must include the following:

(a) The court should specifically order those services necessary to remove the conditions creating the emergency.

(b) The individual lacks the capacity to consent.

(c) The individual lacks the capacity to consent.

(d) The individual lacks the capacity to consent.

(e) The individual lacks the capacity to consent.

(f) The individual lacks the capacity to consent.

(g) The individual lacks the capacity to consent.

(h) The individual lacks the capacity to consent.

(i) The individual lacks the capacity to consent.

(j) The individual lacks the capacity to consent.

(k) The individual lacks the capacity to consent.

(l) The individual lacks the capacity to consent.

(m) The individual lacks the capacity to consent.

(n) The individual lacks the capacity to consent.

(o) The individual lacks the capacity to consent.

(p) The individual lacks the capacity to consent.

(q) The individual lacks the capacity to consent.

(r) The individual lacks the capacity to consent.

(s) The individual lacks the capacity to consent.

(t) The individual lacks the capacity to consent.

(u) The individual lacks the capacity to consent.

(v) The individual lacks the capacity to consent.

(w) The individual lacks the capacity to consent.

(x) The individual lacks the capacity to consent.

(y) The individual lacks the capacity to consent.

(z) The individual lacks the capacity to consent.

(A) The individual lacks the capacity to consent.

(B) The individual lacks the capacity to consent.

(C) The individual lacks the capacity to consent.

(D) The individual lacks the capacity to consent.

(E) The individual lacks the capacity to consent.

(F) The individual lacks the capacity to consent.

(G) The individual lacks the capacity to consent.

(H) The individual lacks the capacity to consent.

(I) The individual lacks the capacity to consent.

(J) The individual lacks the capacity to consent.

(K) The individual lacks the capacity to consent.

(L) The individual lacks the capacity to consent.

(M) The individual lacks the capacity to consent.

(N) The individual lacks the capacity to consent.

(O) The individual lacks the capacity to consent.

(P) The individual lacks the capacity to consent.

(Q) The individual lacks the capacity to consent.

(R) The individual lacks the capacity to consent.

(S) The individual lacks the capacity to consent.

(T) The individual lacks the capacity to consent.

(U) The individual lacks the capacity to consent.

(V) The individual lacks the capacity to consent.

(W) The individual lacks the capacity to consent.

(X) The individual lacks the capacity to consent.

(Y) The individual lacks the capacity to consent.

(Z) The individual lacks the capacity to consent.

(The individual lacks the capacity to consent.)
The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their description, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the state can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model, as set forth below, consists of general systems characteristics which any community should keep in mind when setting up an adult protective services system, a listing of core services which are essential to any protective services system serving elders, a listing of additional services which are largely unavailable to most communities and a delineation of those states which could be most efficiently undertaken on a statewide (as opposed to community) level.

1. General systems characteristics

Within any protective services system there are two essential systems characteristics: first, the necessity of having pre-planned individual case responses or protocols which will initiate the system (and its individual workers) to respond quickly and properly to the type of case being confronted, and second, the capacity for a coordinated, inter-disciplinary response on the part of the service system to both the emergency and chronic conditions exhibited by these cases.

(a) Pre-planned case responses or protocols

Workers with elders who are confronted with abuse or suspected abuse must know what their options are in each situation. Regardless of the emergency or non-emergency nature of the situation, workers must know the service plan options available to them in their community. To the extent that the case is in emergency in nature, the worker's response must be immediate and an immediate response is crucial to the safety of the victim.

- Community workers who are planning a protective services system for abused elders should set as one of their first tasks the development of protocols for the four basic types of abuse, one for each of the ways in which they will take place.

- The client who consents to assessment/service delivery and who appears to be mentally competent.

- The client who refuses assessment/service delivery and who appears to be mentally competent.

- The client who (regardless of his/her degree of cooperation) appears to lack sufficient mental capacity to make decisions regarding his/her own care.

- The client who is in immediate and grievous bodily harm (emergency situations).

There are a number of ways to categorize abuse cases and to develop sub-protocols. The four categories described above are the most basic, however, since they have as a point of reference the client's right and ability to determine the system's response to his/her problem. Also important, the issues confronted by these case typologies (the client's capacity for and right to self-determination) are the very ones which will bring the protective services system to a halt time and time again unless pre-planned responses are available.

(b) Core services

A coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders. The committee's role is two-fold:

- to establish linkages between agencies that will permit services coordination to take place in a timely manner, including the development of protocols as described above.

- to provide an on-going review mechanism for individual cases.

In many communities this dual function might be played by a single inter-agency committee; in others, two groups (agency directors; case managers or caseworkers) may be more logical. These functions might also be performed by a team from one agency assigned by the community to handle cases of elder abuse and having its own internal staff capacity to provide a full range of core services.

2. Core protective services system

While the services required by individual clients will differ, a protective services network for elders should be able to provide a basic group of core services, many of which are currently available in most communities. These core services can be provided through one umbrella agency or through formal agreements between providers. The formal agreements can be contracts to purchase services, but need not involve a transfer of dollars as has been demonstrated by the Council of Elders Protective Services Project, where service units have been allocated to the Protective Services system by other intra-agency service providers.

(a) Protective services workers

Because of the many disciplines and services which must be brought together in an abuse case, it is essential that one person be held accountable for managing the case. This person, the protective services worker, plays a crucial role in linking community resources to the victim and his/her family and in assessing the system's response to changes in the victim's environment. Because it is important to treat the underlying causes of abuse, the protective services worker should also be the means for linking the victim's family and, if possible, the abuser, to supportive and counseling services.

Designating specific persons as protective services workers is an important means of assuring the system's accountability to the client; recent literature also shows the importance of a stable and ongoing client-worker relationship in successfully dealing with abusive situations.

(b) Case assessment team or workers

Once a suspected abuse of an elder is reported, the system must be able to evaluate the need for services, level of services, and the most appropriate response. In the most complete system, this assessment capability could be provided through a team composed of a physician with geriatric experience (or a nurse clinician under the direct supervision of such a doctor), a trained human services worker experienced in gynecology, a social worker, and a self-help group or agency which has a long tradition of working with aging adults.

Not every case of suspected abuse will require a complete evaluation by every member of the team. In some communities, resources might not be available to have such a team permanently on call or in place. In such instances a trained individual could perform an initial assessment, using certain pre-determined protocols or calling in other experts to assure access to a full range of assessment tools.

The assessment team or workers will need to work closely with legal counsel representing the assessment worker and his/her agency. The role of the case manager at this point is to assist the worker in assessing the legal ramifications of the assessment and to work with the client to provide informed judgment as to the proper steps to be taken by the team or worker in proceeding with the case.

(c) Primary health care services

These services may be delivered at-home or on an impatient or outpatient basis.
emergency capacity should at initial thirty a week response capacity is too often counterproductive because it report.

Friends and neighbors may moving the client from victim and family protecting the victim from continuing transportation systems. Friends and neighbors may be helpful in providing this service.

In cases of elder abuse, the victim may be dependent upon the abuser for support, an arrangement which can be temporarily or permanently disrupted. It is important therefore for the protective services system to have some cash-on-hand or other means for assisting the client through this immediate crisis and for arranging more long term alternatives. Private or religious philanthropic groups may be helpful contacts in this area.

Police

Police should be contacted when the client is in imminent danger of bodily harm in order to assure access to the premises and, if necessary, to assist in removing the client from harm. If ambulance services are needed, police can help in arranging this.

Under the new Abuse Prevention Act, police also play an important role in protecting the victim from continuing harm, enforcing restraining or vacate orders and arranging services for the victim. A role for which police presence is not appropriate is in assuring access where imminent danger to the client is not a factor. Indeed, such an overextension of the part of the protective services worker may set up hostility in the alleged victim and family which will be difficult to overcome.

Emergency services provision

The protective services system must be able to provide immediate services to diminish or prevent the threat of grievous bodily harm or death to a client. This emergency capacity should at a minimum include a 24-hour a day, seven days a week, emergency intervention team with the following services:

- emergency housing (at least two nights);
- emergency medical care (in the home or by ambulance to service site);
- emergency funds;
- legal services (for advice or representation of the client);
- emergency services should not be limited to a crisis intervention posture; clients receiving emergency services should be mainstreamed into the client pool as soon as the emergency has been resolved. Reliance on crisis prevention alone is often counter-productive because it tends to regard acute episodes outside the client's day to day functioning.

Follow-up

All cases, regardless of disposition, should be reviewed on a regular basis. An initial review might be conducted by the protective services committee within thirty days of opening a case and each ninety days thereafter. (The long-term nature of abuse cases is discussed in the Literature Review included in this report.)

3. Additional supportive services

The core services listed above, while not evenly distributed or adequately funded in all or even many geographic areas, do exist throughout the Commonwealth. The need is to organize them into protective services units and to assure their availability to victims of abuse.

Other important services are currently unavailable, however, and their unavailability seriously weakens our ability to deal with cases of elder abuse. While individual communities may be able to organize these services for their clients, a national or state-wide effort is needed to assure service availability in all areas.

(a) Emergency shelter/housing

This need constitutes perhaps the single greatest gap in services to victims of abuse. Workers stated again and again their difficulties in locating shelters for elders and their frustration in having to rely upon hospital and nursing home beds for placement of abuse victims.

In some instances, removal of the victim from the abusive environment is the only way in which she can be protected. While hospitals or nursing homes may be suitable placements for certain individuals, alternative, short-term options are needed for many others. State or federally funded demonstration projects are required in this service area. Until such programs are established, existing community facilities should be coordinated to provide emergency shelter for elders. These facilities may include emergency housing resources for other client groups, convents, dormitories on college campuses, motels, guest houses, and public housing authorities.

(b) Counseling groups for victims of abuse and abusers

One of the most difficult problems in dealing with cases of elder abuse is the unwillingness of the victim to talk about it. For various reasons, discussed previously in this report, many battered elders refuses to confront the fact of their victimization. Individualized specialized counseling for abuse victims is often needed throughout the investigation, assessment and service delivery phases of the case. Group counseling may also be an effective means for helping the elder cope with his/her victimization. Models for this type of service are provided by existing self-help groups for victims of rape, for example.

We would also urge that thought be given to the formation of similar self-help groups for abused elders. Private Agencies, an organization of professionals who have assisted our children who has abused their clients, provides us with a successful model in this area.

(c) Foster care for elders

Foster care for elders is a new service concept currently being piloted in a small number of areas in Massachusetts. This and other long-range placement options (such as congregate housing) are necessary for victims of abuse who can no longer live alone or who must be removed from their family's care. Alternative to nursing home placement or hospitalization must be developed for the semi-dependent elder.

(d) Day care or recreational/activity centers for elders

Respite care for elders (both on a regular, daytime basis and for weekends or longer periods of time) gives families who are caring for their elders a break from these sometimes overwhelming responsibilities. Such a service may be provided by an existing day care center, or the personal care of the abuser for weekends or longer periods of time. Either way, it is important to provide these services for governmental assistance for these services.

(e) Long-term care

Long-term care (both in-residence and institutional) is another service that is needed for many individuals who have been the victim of abuse.

(f) Respite care

Respite care for elders (both on a regular, daytime basis and for weekends or longer periods of time) gives families who are caring for their elders a break from these sometimes overwhelming responsibilities. Such a service may be provided by an existing day care center, or the personal care of the abuser for weekends or longer periods of time. Either way, it is important to provide these services for governmental assistance for these services.
flexibility in the way in which protective services responses are permitted to vary from community to community.

Certain elements of a statewide adult protective services system should be uniform, however, and are discussed below. Communities should not be deterred from start-up activities because such uniformity does not currently exist, however.

(a) Standardized record keeping

The protective services system will be improved by standardized record-keeping which permits audits for service and client characteristics. Records should reflect service goals as well as casework process and should be kept by client number so that confidentiality can be maintained during case reviews. Uniform record-keeping creates both a data gathering capacity for planning purposes and a case review capacity which would promote (if not ensure) timely handling of cases. Systematic reviews of individual client progress and adequate fair hearing and grievances procedures for clients and their families. An annual report based upon this information should be prepared by the designated state agency.

(b) Uniform eligibility guidelines

Adult protective services are Title XX eligible services, which, when included in the state plan, must be provided without regard to income. A serious response to the problem of elder abuse would include the provision of adult protective services through Title XX. The question of whether to include disabled persons over eighteen years of age in any statute which mandates adult protective services, or to confine legislation to the sixty plus population is obviously an important one, since this decision will have an impact on the design of the services delivery system and the total cost of the program.

(c) Uniform system of case finding, reporting, and referral

While it is not essential that a single agency be designated in each area for receiving reports of elder abuse, or that that agency be identical across all areas of the Commonwealth, it is important that this responsibility be clearly pinpointed in each area or community of service. A network of agencies, such as visiting nurse associations or hospital, could be designated to perform this function and to be responsible for subsequent referral to other community organizations. While Home Care Corporations might be logical choices in some communities, DRA is reminded that other, possibly equally adequate service providers may be available and should not be discounted.

Regardless of which agency is designated in each area of community, its responsibility should be to receive the report of abuse, assignment of an assessment worker or team to investigate each report and referral of the case to a protective services team or network (internal or external to the agency) for case planning and services delivery. This agency should receive regular status reports on all referred cases.

(d) Confidentiality

LRSE staff found that a great deal of confusion and uncertainty exists around issues of confidentiality as they relate to elder abuse cases. Because of the need for coordinated service responses, it is necessary to share client information across a number of agencies when dealing with cases of elder abuse. In instances where abuse is merely suspected, assessment of the problem may often involve client evaluation by more than one profession. Standardized client release forms and procedures for protecting client specific information, for each of the four basic client typologies previously mentioned, would be useful for local communities attempting to establish adult protective services systems. Such uniformity would also go a long way to assuring that the client's right to confidential treatment of identifying information is respected equally in all areas of the Commonwealth.

(e) Training

Protective services workers specializing in elder abuse, counselors, assessment team members, I & X and emergency telephone personnel—indeed, most persons who would participate in a protective services system for abused elders—need training. In other sections of this report we have outlined the complexity of the issues faced when dealing with abuse and the need to sensitive workers to this newly discovered problem. Traditional skills in case management, record keeping, community organization and case work are also essential in the successful implementation of a state financed and organized efforts particularly through Title XX (SSA) and Title IV-E (OAA) Training Programs.

(f) Funding

Although communities can begin the systems development work outlined above, certain vital services (such as emergency shelters for elders) do not currently exist (such as the protective services worker) may not be available in most communities for abused victims because of existing caseloads or waiting lists. Priority and serious effort is to be made to address the problem of elder abuse. Title XX, Medicare, Title III (OAA) and other sources of services funding should be specifically directed to this problem area.
APPENDIX 2

STATE OF CONNECTICUT, DEPARTMENT ON AGING,
Hartford, Conn.

TESTIMONY ON CONNECTICUT'S ELDERLY PROTECTIVE SERVICES LAW

My name is Jacqueline Walker. I am the State Ombudsman with Connecticut's Department on Aging. I am here to testify on Connecticut's experience with abuse and neglect of the elderly.

In July 1977 Connecticut passed two important pieces of legislation dealing with the frail elderly. One bill was "An Act establishing a Reporting Law for Protection of the Elderly and the Elderly Protective Services Program." The other was "An Act creating the Elderly Protective Services Program." Both pieces of legislation went into effect the following January 1978. That program, within a special unit called the Elderly Protective Service Unit, consists of primarily professional people such as nurses, physicians, police, and family service agencies but now could produce statistical information. Fortunately, however, the legislation passed both the House and Senate with no problems. This program went into effect, in part, to the effort put forth by Representative Batchelor, former Commissioner on Aging and Chairman of the Governor's Blue Ribbon Committee to Investigate the Nursing Home Industry in Connecticut.

The Ombudsman Office is funded with $55,000 which covers the salaries of the staff as well as the operating expenses of the office. The staff is comprised of a State Ombudsman and five Regional Ombudsmen who work out of the five health planning and services areas of the state. The Ombudsmen are responsible for receiving and resolving nursing home complaints and problems presented to them by families, friends, patients, and nursing home administrators and residents which concern the lifestyles and care of the patients in nursing homes, rest homes, and houses for the aged. The Ombudsmen Program went into effect upon passage of the legislation, July 1, 1977. The Protective Services Program went into effect the following January 1978. That program utilizes two state agencies and functions in the following manner. Mandatory Reporters consisting of primarily professional people such as nurses, physicians, police, social workers, ministers, etc. are required to report suspected or known cases of abuse, neglect, abandonment and exploitation of elderly persons 60 years of age or older to the Ombudsman Office. They may report the case either to the State Ombudsman or to one of the five Regional Ombudsmen. On receipt of such a report, the Ombudsman is required to make an immediate investigation and resolution of the problem. This requires a personal interview with the client as well as contact with as many involved agencies and family members as are available. Once a decision has been made by the Ombudsman that, indeed, there is evidence of neglect, abuse, etc., the Ombudsman discusses the problem and possible solutions with the client. The Ombudsman suggests a course of action including types of protective services which will benefit the client in his/her present circumstances.

If the client agrees to this assistance, the Ombudsman then refers the problem to the Elderly Protective Service Unit within the Department of Human Resources, which is divided into small district offices of the State. Within each district office is a special unit called the Elderly Protective Service Unit. This unit is responsible for the supervision of the case. In addition, meetings are held between the Protective Services Program and the Ombudsman to exchange information and makes provisions for those services to be provided. The types of services may include such things as: a home visit, home aide, public health nurse, hospitalization, conservatorship, financial management, counseling or psychiatric evaluation. In those cases where a client refuses services which are offered, it is up to the Ombudsman to make a determination as to the competency of the client. Because the Ombudsman spends a fair amount of time with each client, therefore, he has the opportunity of utilizing the mental status quotient as well as other methods of testing in order to ascertain whether or not the patient is capable of making decisions. If, in the judgment of the Ombudsman, the client appears to be incompetent and thus is incapable of making a decision, the Ombudsman then refers the case to the protective services worker and writes those findings. When the protective services worker follows up on the case, he/she will, in turn, make an additional judgment as to the competency of the client before any services are provided. It is important to remember that the purpose of the program is not to interfere with the rights of self determination of a person. Rather it is to try to provide services for a person who is in a dire situation and who can benefit from some type of intervention. Frequently, the Ombudsman and/or the protective services worker are able to obtain a psychiatric evaluation of that client. There have been some instances where a client is capable of making decisions but realizes that he/she has only a few months to live and simply does not want any help. In instances like these we do not interfere and they make their own decisions and live and die as they choose.

This program also developed a close working relationship with the probate court system in Connecticut. At the time this program went into effect, another important piece of legislation was passed, namely, "An Act establishing a Reporting Law for Protection of the Elderly and the Elderly Protective Services Program." The Ombudsmen as well as the protective services workers met with the probate judges in every town in Connecticut to discuss the responsibility which would be put on the judges with the appointment of emergency or temporary conservators for those individuals requiring immediate attention and protection.

On January 1978, the total number of reported cases is 507, with the total number of problems associated with those cases 612. Of these reported cases there were 161 concerning neglect, 318 concerning abuse, 109 concerning exploitation, and 61 concerning neglect and abuse as noted by the client. The Ombudsman is required to file a report to make a determination as to the competency of the client before any services are provided. None of the cases which were taken from our files from the past year.

In order to more fully emphasize the workings of the program and the types of cases that we receive, I would like to relate to you a few typical examples of cases which were taken from our files from the past year.

1. Mr. and Mrs. A live in an apartment over a store. Their son age 32 lives with them. They are the only tenants in the building. The son has been phys-
ally abusing his parents for many years. The incidents usually follow arguments over money. The son demands money and when his father refuses the son attacks him. The last incident was in March 1970 between 10 and 11 p.m., and a surgery was performed. The mother was struck in the back with a frying pan and the father was clubbed with a stick. According to the police, the son has been a problem since he was a child, but the defendants have had psychiatric help in the past. They were arrested only to be released by the police. The son told the police that if they sent him to Connecticut Valley Psychiatric Hospital he would kill them when he got out.

The son refuses to leave the apartment and the parents are terrified. They refuse to return to the apartment. The father is a cardiac patient and a diabetic. He suffered a heart attack after the previous instance of abuse. The recommendations by the Ombudsman were that the son should not be allowed to remain in the community and that he need psychiatric evaluation and possible placement in the State mental hospital. The parents feel that he needs lifetime placement in the mental hospital. The parents will require a protective environment as well as counseling while the arrangement for the son's care is being made. The report was made to the protective service unit for follow up. These two people arrived at the Veteran's Hospital because of what had just happened. The Veteran's Hospital physician called the Ombudsman who arrived on the scene. The patient was not clear on how this history was taken. The result of this evaluation has been a psychiatric evaluation and was admitted to the Connecticut Valley Hospital. There is some question as to what will happen if and when he is discharged. However, when the protective service unit took over the responsibility of this case, the Ombudsman agreed to follow this person the entire time until he is discharged. When and if the son is discharged from the hospital, they will receive advanced notice of his discharge and can then make the appropriate arrangements for the protection of the parents.

Another case concerns a woman who is presently a resident at a home for the aged in Connecticut. According to the complaint, she was kidnapped from her home in Indiana and was brought here against her will. She is arthritis with high blood pressure, and has been hospitalized twice for heart failure in the past month and a half and is currently in intensive care in a local hospital. She does not have anything of her own at this time. Additionally, neither her Social Security check or her pension have been received since her arrival in Connecticut. She says that as of the date of her arrival in Connecticut, she was kidnapped from her home in Indiana and was brought here against her will. She is Kyoto from a large table and large helpings of meat. Her left leg is Von Willebrand disease. Her left leg is insensitive, the infected condition exists, her foot is an axam wrap around it to "shrink" it. This odor is in the house is a putrid stomach sap. When her father died, a coiner. The conservator is a cousin who has very little to do with the client other than pay her bills. The client is fairly bright in most conversations, however, delivered but has no refrigerating refrigerator. She uses only three rooms of the usual, there are times when she seems to appear to be extremely confused. She has had good house and she sleeps on a filthy, dirty, torn, stained couch. The floors and examples absolutely need medical attention. After referring this case to the Social Service protection of the parents.

The case of a young girl who was a client of the Ombudsman. The client, she was kidnapped by her niece and brought to Connecticut where she was turned out of her home in Indiana. The niece threatened to kill her if she returned to Indiana. This client has expressed a desire to file criminal charges against her niece for the theft of her money and from the treatment she received from her niece for the past several months. The exact date of her kidnapping is yet unclear. In addition to referring this case to the protective services unit, she was also notified to the Connecticut State Police and the Social Security Administration. At this particular time the niece is still being sought in New York where she headed after leaving her niece in Indiana. The niece was not notified of her programs, checks, and the VA pension checks which had been missing were being re-turned and are now coming to her at the home for the aged.

A case concerns a couple who live together in lower Fairfield county. The couple lives in what was once a lovely home. The house now has an infected problem in the heat, and the parents are terrified. They refuse to return to the apartment. The father is a cardiac patient and a diabetic. He suffered a heart attack after the previous instance of abuse. The recommendations by the Ombudsman were that the son should not be allowed to remain in the community and that he need psychiatric evaluation and possible placement in the State mental hospital. The parents feel that he needs lifetime placement in the mental hospital. The parents will require a protective environment as well as counseling while the arrangement for the son's care is being made. The report was made to the protective service unit for follow up. These two people arrived at the Veteran's Hospital because of what had just happened. The Veteran's Hospital physician called the Ombudsman who arrived on the scene. The patient was not clear on how this history was taken. The result of this evaluation has been a psychiatric evaluation and was admitted to the Connecticut Valley Hospital. There is some question as to what will happen if and when he is discharged. However, when the protective service unit took over the responsibility of this case, the Ombudsman agreed to follow this person the entire time until he is discharged. When and if the son is discharged from the hospital, they will receive advanced notice of his discharge and can then make the appropriate arrangements for the protection of the parents.

A case concerns a couple who live together in lower Fairfield county. The couple lives in what was once a lovely home. The house now has an infected problem in the heat, and the parents are terrified. They refuse to return to the apartment. The father is a cardiac patient and a diabetic. He suffered a heart attack after the previous instance of abuse. The recommendations by the Ombudsman were that the son should not be allowed to remain in the community and that he need psychiatric evaluation and possible placement in the State mental hospital. The parents feel that he needs lifetime placement in the mental hospital. The parents will require a protective environment as well as counseling while the arrangement for the son's care is being made. The report was made to the protective service unit for follow up. These two people arrived at the Veteran's Hospital because of what had just happened. The Veteran's Hospital physician called the Ombudsman who arrived on the scene. The patient was not clear on how this history was taken. The result of this evaluation has been a psychiatric evaluation and was admitted to the Connecticut Valley Hospital. There is some question as to what will happen if and when he is discharged. However, when the protective service unit took over the responsibility of this case, the Ombudsman agreed to follow this person the entire time until he is discharged. When and if the son is discharged from the hospital, they will receive advanced notice of his discharge and can then make the appropriate arrangements for the protection of the parents.

A case concerns a couple who live together in lower Fairfield county. The couple lives in what was once a lovely home. The house now has an infected problem in the heat, and the parents are terrified. They refuse to return to the apartment. The father is a cardiac patient and a diabetic. He suffered a heart attack after the previous instance of abuse. The recommendations by the Ombudsman were that the son should not be allowed to remain in the community and that he need psychiatric evaluation and possible placement in the State mental hospital. The parents feel that he needs lifetime placement in the mental hospital. The parents will require a protective environment as well as counseling while the arrangement for the son's care is being made. The report was made to the protective service unit for follow up. These two people arrived at the Veteran's Hospital because of what had just happened. The Veteran's Hospital physician called the Ombudsman who arrived on the scene. The patient was not clear on how this history was taken. The result of this evaluation has been a psychiatric evaluation and was admitted to the Connecticut Valley Hospital. There is some question as to what will happen if and when he is discharged. However, when the protective service unit took over the responsibility of this case, the Ombudsman agreed to follow this person the entire time until he is discharged. When and if the son is discharged from the hospital, they will receive advanced notice of his discharge and can then make the appropriate arrangements for the protection of the parents.

A case concerns a couple who live together in lower Fairfield county. The couple lives in what was once a lovely home. The house now has an infected problem in the heat, and the parents are terrified. They refuse to return to the apartment. The father is a cardiac patient and a diabetic. He suffered a heart attack after the previous instance of abuse. The recommendations by the Ombudsman were that the son should not be allowed to remain in the community and that he need psychiatric evaluation and possible placement in the State mental hospital. The parents feel that he needs lifetime placement in the mental hospital. The parents will require a protective environment as well as counseling while the arrangement for the son's care is being made. The report was made to the protective service unit for follow up. These two people arrived at the Veteran's Hospital because of what had just happened. The Veteran's Hospital physician called the Ombudsman who arrived on the scene. The patient was not clear on how this history was taken. The result of this evaluation has been a psychiatric evaluation and was admitted to the Connecticut Valley Hospital. There is some question as to what will happen if and when he is discharged. However, when the protective service unit took over the responsibility of this case, the Ombudsman agreed to follow this person the entire time until he is discharged. When and if the son is discharged from the hospital, they will receive advanced notice of his discharge and can then make the appropriate arrangements for the protection of the parents.
services to the elderly person.

---

...or any person who makes any report pursuant to this act, or who testifies in any administrative or judicial proceeding arising from such report shall be immune from any civil or criminal liability on account of such report or testimony, except for liability for perjury, if such person acted in bad faith or with malicious purpose.

Sec. 3. (a) The commissioner upon receiving a report that an elderly person is being, or has been, abused, neglected, exploited or abandoned, or is in need of protective services shall cause a prompt and thorough investigation to be made through the regional ombudsman to determine the facts and circumstances relative to the condition of the elderly person and what action and services, if any, are required. The evaluation shall include a visit to the named elderly person and consultation with those individuals having knowledge of the facts of the particular case. Upon completion of the evaluation of each case, written findings shall be prepared which shall include recommended action and a determination of whether protective services are needed. The person filing the report shall be notified of the findings, upon request.

(b) Each regional ombudsman shall maintain a registry of the reports received, the evaluation and findings and the actions recommended, and shall furnish copies of such data to the department on aging for a statewide registry.

(c) Neither the original report nor the evaluation report of the regional ombudsman shall be deemed a public record or be subject to the provisions of section 1-31a of the general statutes. The name of the person making the original report or any person mentioned in such report shall not be disclosed unless the person making the original report specifically requests such disclosure or unless a court of competent jurisdiction shall so order.

Sec. 4. (a) If it is determined that an elderly person is in need of protective services, the regional ombudsman shall refer the case to the appropriate department or agency for provision of necessary services, provided the elderly person consents. If the elderly person fails to consent and the regional ombudsman has reason to believe that such elderly person lacks capacity to consent, the regional ombudsman shall refer the case to the department of social services for a determination pursuant to section 7 of this act of whether protective services are needed. The person filing the report shall be notified of the findings, upon request.

(b) If the caretaker of an elderly person who has consented to the receipt of reasonable and necessary protective services refuses to allow the provision of such services, the commissioner of the department of social services may file a petition in the superior court for an order enjoining the caretaker from interfering with the receipt by the elderly person of the necessary services.

The petition shall allege specific facts sufficient to show that the elderly person is in need of protective services. The petition shall further state the name and address of the involved elderly person, information regarding the nature and extent of the abuse, neglect, exploitation or abandonment, and any other information which the commissioner believes might be helpful in an investigation of the case and the protection of such elderly person.

(c) Any other person having reasonable cause to believe that an elderly person is being, or has been, abused, neglected, exploited, or abandoned, or is in need of protective services may make such report to the commissioner or his designee.

(d) Any person who makes any report pursuant to this act, or who testifies in any administrative or judicial proceeding arising from such report shall be immune from any civil or criminal liability on account of such report or testimony, except for liability for perjury, if such person acted in bad faith or with malicious purpose.

Sec. 5. Any person, in any administrative or judicial proceeding arising from such report, shall be immune from any civil or criminal liability on account of such report or testimony, except for liability for perjury, if such person acted in bad faith or with malicious purpose.

Sec. 6. No complaint alleging the abuse, neglect, exploitation or abandonment of any resident of Connecticut who is sixty years of age or older shall be entertained without the consent of such person unless the complainant is a legal representative of such person.

Sec. 7. This act may be cited as "Protection of the Elderly Act."
any elderly person, subject to any specific requirement for individual consent, and the right to authorize the transfer of an elderly person from a nursing home.

CONSENT

Sec. 6. (a) If an elderly person does not consent to the receipt of reasonable and necessary protective services, or if such person withdraws the consent, such services shall not be provided or continued, except that if the commissioner of social services has reason to believe that such elderly person lacks capacity to consent, he may seek court authorization to provide necessary services, as provided in section 7 of this act.

(b) The department of social services, within ten calendar days of the receipt of any case for the provision of protective services, shall furnish the regional ombudsman a written report outlining the intended plan of services. The regional ombudsman shall have the right to comment on the proposed plan, and a copy of the regional ombudsman's comments shall be forwarded to the state ombudsman for subsequent action, if required.

APPOINTMENT OF CONSERVATOR

Sec. 7. (a) If the commissioner of social services finds that an elderly person is being abused, neglected, exploited or abandoned and lacks capacity to consent to reasonable and necessary protective services, he may petition the probate court for appointment of a conservator of the elderly person pursuant to the provisions of chapter 779 of the general statutes, in order to obtain such consent.

(b) Such elderly person or the individual, agency or organization designated to be responsible for the personal welfare of the elderly person shall have the right to bring a motion in the cause for review of the probate court's determination regarding the elderly person's capacity or an order issued pursuant to this act.

(c) The probate court may appoint, if it deems appropriate, the commissioner of social services to be the conservator of the person of such elderly person.

(d) In any proceeding in probate court pursuant to provisions of this act, the probate court shall appoint an attorney to represent the elderly person if he is without other legal representation.

USE OF OTHER HUMAN SERVICE AGENCIES

Sec. 8. (New) In performing the duties set forth in this act, the regional ombudsman and the department of social services may request the assistance of the staffs and resources of all appropriate state departments, agencies and commissions and local health directors, and may utilize any other public or private agencies, groups or individuals who are appropriate and who may be available.

Sec. 9. Subsequent to the authorization for the provision of reasonable and necessary protective services, the department of social services shall conduct a review of each case within forty-five days, to determine whether continuation of such services is warranted. A decision regarding the provision of such services should be made in concert with appropriate personnel from other involved state and local groups, agencies and departments, and shall comply with the consent provisions of this act. Reevaluations of each such case shall be made every ninety days thereafter. The department of social services shall advise the appropriate regional ombudsman and other entities about the continuation of protective services for each such elderly person.

Sec. 10. Prior to implementation of any protective services, an evaluation shall be undertaken by the department of social services, pursuant to regulations which shall be adopted by the commissioner of social services, in accordance with chapter 54 of the general statutes, regarding the elderly person's financial capacity for paying for the protective services. If the person is so able, procedures for the reimbursement for the cost of providing the needed protective services should be initiated. If it is determined that the person is not financially capable of paying for such needed services, the services shall be provided in accordance with policies and procedures established by the commissioner of social services for the provision of welfare benefits under such circumstances.

Sec. 11. If as a result of any investigation initiated under the provisions of this act, a determination is made that a caretaker or other person has abused, neglected, exploited or abandoned an elderly person, such information shall be referred in writing to the appropriate office of the state's attorney, which shall conduct such further investigation, if any is deemed necessary and shall determine whether criminal proceedings should be initiated against such caretaker or other person, in accordance with applicable state law.
Under a new law which took effect in 1978, the State of Connecticut Department on Aging and Social Services are working together to provide help to elderly persons 60 years of age and older who are victims of abuse, neglect, exploitation, or abandonment.

The new law, P.A. 77-613, authorizes these two state agencies to cooperate in the investigation of any reported cases of abuse, neglect, exploitation, or abandonment of the elderly. If the investigation shows the older person is in need of protective services, the State may intervene and arrange for the care of the aged individual through relatives, or friends, or a court appointed conservator.

The State may, with the consent of the elderly person or a conservator, provide for such services as day care, homemaker services, chore services, meals on wheels, health care, and shelter.

MANY OBLIGED TO REPORT

The new law mandates that a wide range of persons whose work brings them into contact with the elderly report cases of abuse, neglect, exploitation, or abandonment to one of six Department on Aging Ombudsmen listed in this pamphlet.

Those persons required to report to the Ombudsmen include: physicians, surgeons, interns, registered nurses, licensed practical nurses, medical examiners, dentists, osteopaths, optometrists, chiropractors, podiatrists, social workers, coroners, clergy, police officers, pharmacists, physical therapists, nursing home administrators, nursing home aides, nursing home orderlies, all nursing home staff, regional ombudsmen for the aging, patient advocates.

TIMELY REPORTING REQUIRED

The mandatory reporters listed above are required to report to the Ombudsmen for Aging within five calendar days of the time the suspected abuse, neglect, exploitation, or abandonment is discovered.

The reporter should provide the Ombudsmen with at least the name and address of the involved elderly person and information regarding the nature and extent of the abuse, neglect, exploitation, or abandonment.

PENALTIES AND IMMUNITY FOR REPORTERS

Any mandatory reporter who has reasonable cause to suspect or believes that an elderly person has been abused, neglected, exploited, or abandoned, and fails to report as required, shall be fined not more than $250.

Legal immunity from any civil or criminal liability related to a mandatory report is provided to those who report in good faith, except for cases of perjury.

THE RIGHTS OF THE ELDERLY PERSON

There are a number of provisions tailored to protect the rights of the elderly persons who may need protective services.

DEFINITIONS

"Abuse" includes, but is not limited to, the willful infliction of physical pain, injury or mental anguish, or the willful deprivation of a caretaker, of services which are necessary to maintain physical and mental health.

"Neglect" refers to an elderly person who is either living alone and not able to provide for him/herself the services which are necessary to maintain physical and mental health or is not receiving necessary services from the responsible caretaker.

"Exploitation" refers to the act or process of taking advantage of an elderly person by another person or caretaker whether for monetary, personal, or other benefit, or gain or profit.

"Abandonment" refers to the desertion or willful forsaking of an elderly person by a caretaker or the failing of duties and obligations owed an elderly person.

Consent—Elderly persons must give their consent before services are arranged for them.

Formal Hearing on Competency—if it is felt that an elderly person lacks the capacity to give consent for State intervention, a petition for custody of the person may be filed in Probate Court. The elderly person must be represented by an attorney during these proceedings.
END