LATE
Testimony

Testimony on Elder Abuse

By
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Presented to Committee on Human Services
Chair: Representative John M. Mizuno
Vice-Chair-Representative Tom Brower
Thursday, April 1, 2010, 9:00am – 10:15am
Conference Room 329

The mission of Child and Family Service is strengthening families and fostering the healthy development of children. We do this by providing services from our youngest Keiki to our oldest Kupuna. Hawaii's strength comes from its `Ohana which includes our elders. With in our Gerontology Programs we deal with the issue of Elder Abuse through our REACH Program as well as our other case management and care giving programs.

The REACH Program was designed to provide an array of interventions and services to address the needs of individuals at risk for abuse and neglect, including self neglect. We work with a variety of seniors each with differing needs and conditions requiring a range of interventions. REACH has proven to do so with great effectiveness. We would like to testify on the condition of Elder Abuse from our experiences in working with this population for the past eight years.

THE PROBLEM

Elder abuse and neglect is a problem in Hawaii as it is elsewhere in the U.S., but the precise dimensions of the problem are unknown due to under-reporting. There are some variations in how abuse is defined, however for our purposes abuse includes physical, emotional/ psychological, financial, sexual, neglect by others, either intentional or unintentional or abandonment and self-neglect. The National Center on Elder Abuse *2004 Survey of Adult Protective Services* cites a total of 565,747 reports of elder and vulnerable adult abuse for persons of all ages. This represents a 19.7% increase from their previous survey in 2000 (472,813 reports). Of these figures, those 60 years old and over accounted for 253,426 (40%) from the 32 states that separated out their data by age. Self-neglect was the most common category of investigated reports (49,809 reports or 26.7%), followed by caregiver neglect (23.7%), and financial exploitation (20.8%), within the 19 states that supplied these statistics. There has not been a follow up report done nationally.

Based on national estimates that the frequency of elder abuse ranges from five to ten percent of the elder population, and considering that there are just over 180,163 elders 60 years of age or older on Oahu, a large gap between those receiving services and those possibly experiencing abuse is noted. While the Adult Protective Services (APS) is concerned with abuse and neglect of vulnerable adults of various ages, in FY 2007 there were 711 (73%) cases reported on Oahu that were age 60 and older. A total of 335 (48%) of those reported were investigated and 79

(24%) of those cases were confirmed as being abusive. A total 84% of confirmed cases of abuse on Oahu were age 60 and older. These numbers are similar on all islands.

APS is the main public agency which responds to reports of elder abuse, defined as actual or imminent physical injury, psychological abuse or neglect (including threats), sexual abuse, financial exploitation, negligent treatment, or maltreatment among dependent adults. Their role is to investigate the report, determine if abuse or neglect has occurred, and take the immediate necessary steps to protect the person from further harm. However, the agency is able to address only a part of the whole picture of abuse, neglect, and self-neglect: *APS will intervene only when an adult is shown to be vulnerable and at risk of imminent harm.* Because of this legal limitation, APS is not able to help in situations where help is needed, but abuse or neglect is not clearly substantiated. Nor can it intervene when elders are obviously at risk of maltreatment or self-neglect, and the elder would be consenting to receiving help, but they are not "vulnerable". Even if the elder is vulnerable and at risk of imminent harm, they may, if legally capable of making decisions, refuse APS services. Further, APS is not staffed to provide on-going care past the immediate intervention and case management.

In Hawaii, the Adult Protective Services Unit of the Hawaii Department of Human Services investigated an average of 573 reports per year of suspected abuse or neglect statewide between 2001 and 2005. According to a REPORT TO THE TWENTY-FOURTH HAWAII STATE LEGISLATURE 2008 from the Department of Human Services (DHS), Social Services Division dated January 2008 in FY 06-07 there were a total of 1,387 cases reported statewide with 575 investigated and 118 confirmed. Of these 37% were in the 80+ age category, 53% were abused at home, 34% were relatives of the victim, and 25% were self-neglectful. On Oahu alone, for elders age 60 and over the number of reported cases were 711 with 335 cases investigated and 95 confirmed cases of abuse.

It should be noted that during the period of this report the APS mandate was for dependent adults. This was changed to vulnerable in 2009. Among the reports for seniors not accepted for investigation Poor Self-Care (24%) and Neglect by Others (29%) were among the top complaints. This was followed by Financial Exploitation (19%), Psychological Abuse (16%) and Physical Abuse (11%). Sexual Abuse was reported in 1% of the cases. There were similar percentages in the cases that were investigated: Neglect by others (30%) and Poor Self Care (24%), Financial Exploitation (19%), Physical Abuse (12%), Psychological Abuse (14%) and Sexual Abuse 1%.

A random sample was pulled to determine the reason behind the report not being investigated. They noted that 24% were not dependent on others, and in 30% there was no indication abuse occurred AND no risk of imminent harm. In 16% there was no indication of abuse but there was a risk of imminent harm and in 30% of the cases abuse occurred BUT there was no risk of imminent harm. In 20% of the cases not investigated the client was referred to case management agencies other than DHS.

There are a number of abused or neglected seniors who harbor an unfounded fear that APS, as an agency of the State, can do them some harm, such as revoke their welfare payments. They may be willing to consent, however, to services without the stigma of State intervention. REACH was created to address these gaps in services for elders at risk and provide appropriate interventions and case management services.

THE COMPLEXITY OF ELDER ABUSE

To fully understand the depth and breadth of Elder Abuse, it is important to look at the variety of Abuse situations.

At the far end of the continuum of Domestic violence are those people who are now over 60, who after many years of abuse have decided to get out of the relationship. Their needs are similar to the needs of younger relationship violence individuals but with the possible addition of needing help with physical limitations. This limits their ability to utilize shelters as they are not equipped to help those with needs for help with ADLs / IADLs.

Another face of Elder Abuse is individuals who are being taken advantage of by others. These are seniors who may be independent but fall victim to scams, fraud or others taking advantage of them. Sometimes these are family or friends who are facing tough economic times, substance abuse issues and other times the senior may be "collateral damage" as was recently seen in the murder of a woman in Hawaii Kai.

The stress of care giving also impacts seniors who are more dependant or vulnerable. We have seen cases where spouses, themselves having physical limitations, caring for the more dependent spouse. Younger family members are being overwhelmed by work, family and other obligations and are having difficulty providing the help a senior may need. They may be dealing with a senior with issues they are not equipped to deal with such as a senior who is resistant to care, having violent outbursts or even how to care for someone as they decline in function.

Older adults subject to self-neglect and those who are at risk for elder abuse and neglect essentially represent different service needs. Elders who are self-neglecting are more often without a social support system which might intervene to provide support and care. They are also more likely to have cognitive losses, mental health issues, or personality disorders, and not fully realize they are neglecting their own well-being. These cases often require much time for rapport-building, intense community collaboration, and more individual supportive services for the senior person. In contrast, elders at risk for abuse or neglect by others almost always have a social system around them, quite often a dysfunctional one which does not respect the rights or care for the needs of the older adult. Resolution of the risk in these situations more often involves intervention in the social support or family situation, and may involve legal intervention such as temporary restraining orders. The challenge for community agencies is that services and interventions designed to deal with one of these situations does not necessarily work well with the other.

In addition to the abuse or neglect we have noted that a number of our clients have co-existing mental health problems. These are in part the cause of the self-neglect or at least impact their ability to help themselves. In her testimony to the New York State Assembly Standing Committee on Aging and NYS Standing Committee on Judiciary on Feb. 7, 2008, Risa Breckman, Director of Social Work Programs and Education at Weill Cornell Medical College's Division of Geriatrics and Gerontology stated: "Mental Illness is a significant problem. Over 20% of people over 65 have a mental illness or substance abuse disorder. About 25% have clinically significant symptoms for depressive disorder with 5% suffering major depression. We know from research that Elder Abuse victims suffer from depression more commonly than their non abused counterparts. Depression often leads to social isolation, which is itself a risk factor for abuse. What follows? Hopelessness. This in turn increases the risk of suicide." In a 2000 study "The High Prevalence of Depression and Dementia in Elder Abuse or Neglect", conducted by Carmel Bitondo Dyer, MD, Valory N. Pavlik, PhD, Kathleen Pace Murphy, PhD and David J. Hyman, MD, MPH, it was founded that there was a statistically significant higher prevalence of depression (62% vs 12%) and dementia (51% vs 30%) in victims of self-neglect compared to patients referred for other reasons. When analyzing all victims of Abuse or Neglect compared to self-neglect their findings were similar except the preponderance of males with the diagnosis of self-neglect did not reach statistical significance. They go on to say "The finding of a high prevalence of depression in neglected patients is meaningful for several reasons. Depression can result in a decrease in executive function that can impair the patient's decision making capacity, rendering them unable to make proper judgments about their care. Depression may be a major reason why neglected patients, especially those suffering from self-neglect, refuse medical treatment or assistance in the home. It may be why patients neglect their daily needs or allow others to do so."

At the other end of the spectrum is abuse that occurs in the very institutions that are supposed to provide care to dependent adults. Though CFS does not work in this community we do realize that this is a problem as well. The Long Term Care Ombudsman Office is limited in staff to be able to be more proactive in monitoring the multitude of Care Homes, Foster Homes and Nursing Homes. Staffing shortages cause caregivers to be overwhelmed, lack of mandated staffing levels result in Nursing Homes being staffed with the same number of caregivers since the 1970's even though the residents have a higher acuity. Foster Homes and Expanded Care Homes are taking in higher acuity residents because of the lack of Nursing Home beds and hospitals needing to discharge clients. All of these things can lead to abuse and neglect.

CURRENT SERVICES AVAILABLE AND SERVICE GAPS

The Department of Human Services, through its Adult Protective Services is the main public agency which responds to reports of elder abuse neglect and exploitation. Their role is to investigate the report, determine if abuse or neglect has occurred, and take the immediate necessary steps to protect the person from further harm.

In 2008, the Hawaii State Legislature made significant changes to the current Dependent Adult Protective Services Law through Act 154 which will go into effect July 1, 2009. The new law deletes "dependent" from its title. Changes included deleting the term "dependent", adding a more inclusive term, "vulnerable", and giving the DHS the jurisdiction to investigate cases of abuse of a vulnerable adult who has incurred abuse or is in danger of abuse if immediate action is not taken.

Within APS there is a Victims of Crime Act (VOCA) program designed to provide case management to victims of elder abuse and neglect. The VOCA unit in APS has experienced success at providing case management for elder abuse and neglect victims, although this funding is year-by-year with no long-range guarantees.

The City and County of Honolulu also has a Victim/Witness Kokua program managed by the Department of the Prosecuting Attorney, whose target population includes elderly/senior victims of abuse and neglect. Services are rendered only in connection with prosecution of cases, and limited to the period of such legal action.

The City and County of Honolulu, Department of the Prosecuting Attorney recently appointed Scott Spallina to the Elder Justice Unit and there have been increased efforts to inform the public that Elder Abuse is a crime. These services are also related to the prosecution of cases.

There are a number of senior case management programs on Oahu that have income and situational eligibility criteria, the Kupuna Care Senior Case Management at CFS and Kokua Kalihi Valley Comprehensive Family Services. Other fee-for-service, private case management companies such as Options for Elders and Eldercare Resources address a small number of clients with financial resources.

In addition, the mental health service providers in Hawaii have faced substantial cuts in their funding and serve a very limited clientele. In addition they are ill equipped to deal with the needs of the geriatric client and are at times uncomfortable in dealing with geriatric clients. We have received calls from these providers asking that we help them with cases of older clients with long standing mental health issues. They are also reluctant to accept referrals from us related to clients being older.

There continues to be a gap in affordable legal services for abuse, neglect and self-neglect clients. Besides the University of Hawaii Law School's UHELP; which does serve this population but has income and asset limitations; and Volunteer Legal Services, which has a small staff and limited services, the legal community does not serve this needy population well. There are no services to assist in obtaining guardianship for seniors who are no longer competent and need someone to make decisions for them. If a case is accepted by APS, they will sometimes obtain guardianship, however this is limited. Even is a family member is willing to pursue guardianship, there are very few affordable legal options.

There is also a gap in money management services to assist those who have difficulty managing their finances. Comfort, Security and Independence (CSI), Inc. primarily serves those who have the assets to pay for services, and Catholic Charities has closed its management program. There is a need for professional Representative Payees to assist those without family support to help protect them from abuse.

There are many agencies, businesses and programs that provide the first line of recognition that abuse may be occurring. Banks often will report concerns that have about long time customers suddenly changing their banking habits. Senior Centers, Home delivered meals or meal sites, Day cares and Day Health Programs often can see changes in the person or see symptoms of abuse. Educating them so they are more aware can be helpful.

Police and other first responders may need to be more aware of indicators of elder abuse. Although it may not be the reason for the initial call, noting frail seniors in a home can be an indication that there may be other problems in the home. For example, just as we look at a home situation for children, we need to also look at that same situation for a frail and vulnerable senior.

OTHER FACTORS IMPACTING ELDER ABUSE:

Reduction in the Mental Health Program Services has caused seniors to decline as there are no ongoing support services monitoring their condition. If the senior decompensates, they may make more poor choices, become self neglectful or risk homelessness.

APS has changed the process of getting registry checks and is now charging for an APS Registry Check to be done. Per APS, checks should be completed yearly to insure that no other instances have occurred since the last check. This is a cost of minimally 13.50 per check, which, for large agencies/ programs etc. can be a large cost. It is also more difficult if you are not one of the programs mandated by contract to do these checks. Our Caregiver Respite Program maintains a database of care providers that are prescreened which are linked to people looking for respite workers. There are no funds to pay for these checks as they had always been free. Looking forward it would cost our program an additional $2,500 each year to receive this information. We do criminal background checks, however many people found to have committed abuse by APS are not prosecuted or found guilty.

The economy has affected everyone. Decrease in services, minimum staffing, families now struggling as they lose their jobs. These add stress to all the other factors that come to play in Elder Abuse situations.

SOLUTIONS :

The first thing that comes to everyone's mind is funding. In this economy we are struggling to keep services. We need to look at revenue generating solutions that can provide the funding for services that are needed. As the number of seniors rise, so does the need for services which means an increase in the funding levels.

In addition, there are other ways to help prevent and address the needs of those at risk. These include:

Services promoting prevention, addressing the needs of family caregivers, offering safe places for seniors to go if they need to leave the situation but are in need of some assistance.

Greater prosecution of individuals who abuse others. This is very difficult as the victims may not be "good witnesses" for the prosecution. This could be due to dementia, inability to speak (Aphasia) language differences, or fear of retaliation. Many fear they will be placed in an institution if their caregiver is found guilty.

Looking at increasing services that impact the problem such as Mental Health Services, Caregiver Respite services, Senior Centers etc.

We are looking at beginning an Elder Abuse Coalition to bring everyone to the table on this issue. This includes the greater Domestic Violence community as well as the senior network, mental health and legal services.

Prevention – focus on educating the public so that they are more likely to report abuse. Also trying to shift the values we as a community hold. This includes a focus on how we value our seniors. In our State Constitution, Article 9, Section 10 – The Law of the Splintered Paddle - "Let every elderly person, woman and child lie by the roadside in safety" shows that we recognize the value of providing safety for those who may be vulnerable. Let our words guide us in our actions to take a stand against violence, abuse of everyone.

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I am submitting this testimony as a Social Worker who has had a variety of experiences in the field of Domestic Violence and Elder Abuse. I became a Social Worker because I saw the need to advocate for victims of violence. I worked in an Elder Abuse Program in Niagara Falls, NY in the early 1990's, which addressed caregiver abuse. For over 20 years I have worked in nursing homes, starting as a nurse aide in the 70's and for about 13 years in local nursing homes. For two years I was a case manager in a program that worked with care home operators who cared for the mentally ill. During all this time, you can say that I have seen a lot of abuse. Some of the stories would bring tears to your eyes. Recently I have commented to colleagues that it seems that there is one violent crime a month for the past 6-8 months. Although many do not think of Elder Abuse when they hear the stories, I think that there are ties to Elder Abuse there.

There are many differing situations that carry the common thread of Elder Abuse. From a spouse who is 60 or older deciding that they do not want to live their retirement years in an abusive relationship, a senior who marries in later life whose new spouse is abusive and may be experiencing abuse for the first time.

There are seniors who, in trying to help others and fall victim to these individuals taking advantage of them. There are many stories of people who move in to help a senior and have them change their will or power of attorney. People who move their whole family into a senior's home, relegating the senior to a small corner of their own home.

Some seniors, due to dementia and/ or mental illness, may make poor choices or become forgetful and are self neglectful. We have seen individuals living in unsanitary conditions that refuse outside help. Forgetting to reapply for Medicaid and have no funds for rent or food. Some become homeless.

Caregivers feeling overwhelmed in their role can become abusive and neglectful to the dependent senior. They may not be trained to deal with some of the issues such as angry outbursts, resistance to care or even how to bathe their family member. Imagine also having to perform personal care on your parent. There can be feelings of discomfort performing these very intimate tasks.

Then there are the institutions where abuse occurs. After working in Nursing Homes in the early 1970's, I was surprised how much had changed when I returned in the early 1990's. Much of the changes came from the Nursing Home Reform bills that came out in the 1980's. The biggest focus was on resident rights. I find it very sad that there is a culture that talks about resident rights but does not really capture the essence of the rules. Look at the women in the nursing home and notice the hair – always cut short. This is not by the resident's choice but staff telling the hairdresser – "it is easier to take care of". Many residents have a decline in function because the staff does everything for them because it is faster. Residents are wheeled to the dining room instead of walking there.

Imagine being served your lunch, in bed – and when you tell the staff that you had an bowel movement, you are told "I can't do that right now, I have to pass trays. As a Social Worker I would be called to assess a resident who had behavior problems. In looking at the possible causes I would notice that the resident striking out at staff occurred at 3am – when they were trying to give them an enema. Another resident was woken at night for incontinence care. They swung at staff, hitting their arm on the side rail and getting a skin tear. The resident had very fragile skin and sustained 3 more skin tears because the staff insisted to try to hold her down to apply the steri strip to the first tear rather than let her calm down first.

Can you imagine trying to sleep in a room with the lights on all night? As a C.N.A. we used flashlights and over bed lights at night – but in facilities here there are often lights on in the room all night. I have seen staff pinching residents so they will open their mouths so they can get them to eat, one person shaking the resident in frustration. These staff were fired. Others who were accused by the resident - were remained on staff. Even though they were found to have been abusive by APS – the union fought for them and when they went to court – the judge did not find them guilty – and said it was in part because the resident and family did not speak English and were difficult to understand.

The one overwhelming factor I see in Nursing Homes that may be related to abuse, is the lack of staffing. Hawaii does not have minimum staffing guidelines. The staffing levels for C.N.A.s is the same as when I was a C.N.A. in the 70's when the acuity was much lower. There are more Nurses due to the multiple care needs of the residents but the hands on workers remain the same. How can 1 person help feed, toilet, dress and prepare 8 to 10 residents for bed on the evening shift. How about 5 -6 staff on the night shift to do change and reposition round every two hours on 100 residents.

Our care homes also are being affected. Can 1 individual really provide all the care needed for 5 individuals when they are a higher level of care. The definition of ICF ranges from some one needing some assistance to someone needing full assistance. The system of inspections allows individuals to prepare for the inspectors. This coupled with some care homes limiting visiting hours prevents the uncovering of abuse happening. I have worked with many care homes that provide loving care and do wonderful work. I have also seen ones that park people in from of the TV and do the bare minimum. There must be systems in place to monitor and prevent abuses in the facilities.

Much work has been done in the area of making institutions more home like and improving the quality of care for our seniors. People like Dr. Bill Thomas and the Eden Alternative / Green house, show that quality care can be provided for the same Medicaid cost but result in residents maintain or improving their function, being more involved in the life of the home and having a greater quality of life.

Recognizing that Seniors are individuals and have the right to make choices as we all do will help to make their care more appropriate. Training staff how to work with people that have dementia or other issues will help to decrease staff frustration. Respecting the other professionals who are a part of the interdisciplinary team who advocate for residents is essential. Our institutions are more focused on the medical model which takes away the individuality of the care provided. I also feel that companies that put profit over clients are part of the reason for minimum staffing and sometimes poor equipment and sparse supplies. I have had an administrator refuse to purchase new bed pads which were worn until a wealthy family member made the complaint.

Many people involved in the care of seniors come into the field wanting to help. I have seen staff buy things for clients out of their own money because the client's family would not or are not available. I have seen care home operators who have truly make the resident a part of their family, those who can work with the most difficult senior because they are supported and provided with the resources they require.

We need to keep our standards high and monitor to prevent abuse. There is much research to show how this can be done, especially in the facility setting. Lastly, we need to have some teeth in the laws to show this will not be tolerated.

Thank you for allowing me to testify.

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