# ELDER ABUSE: CURBING A NATIONAL EPIDEMIC



## HEARING

BEFORE THE

## SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

## SELECT COMMITTEE ON AGING
## HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

CLEVELAND, OHIO, DECEMBER 10, 1990

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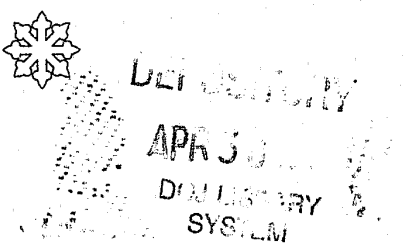

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# ELDER ABUSE: CURBING A NATIONAL EPIDEMIC

MONDAY, DECEMBER 10, 1990

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
*Washington, DC.*

The subcommittee met, pursuant to notice at 9:50 a.m., in Lutheran Medical Center, Franklin Boulevard and Fulton Road, Cleveland, Ohio, Hon. Mary Rose Oakar (acting chairman of the subcommittee), presiding.

Members present: Representatives Oakar and Gillmor.

Staff present: Kathy Gardner Cravedi, Staff Director; Scott Frey, Jan Papez, and Mary Darrah.

## OPENING STATEMENT OF CHAIRMAN MARY ROSE OAKAR

Ms. OAKAR. The Subcommittee on Health and Long-Term Care of the Select Committee on Aging will come to order.

I am just going to do a little test first. Can everyone hear me? Is everything okay? Okay, great.

I am delighted to be here today and be joined by one of my colleagues who I happen to serve with on a number of committees. He is an Ohioan as well. Congressman Paul Gillmor who represents an area that goes all the way from the Lorain County area all the way out along the beautiful lake and into Port Clinton and other areas. So we are very, very happy to have Congressman Gillmor who served so well in the State legislature as well, to be here in an effort to show that this is a bipartisan interest in the subject of elder abuse.

In 1978, I joined forces and I am going to submit my entire statement for the record; with the late great Claude Pepper who was the then Chairman of the House Select Committee on Aging, to investigate the sad, terrible reality of elder abuse. I first came to know about elder abuse and to realize what a national scandal it was, and what a local problem it was when a social worker right here at Lutheran Hospital called my office, interestingly enough. This social worker indicated that there was an individual who was older who kept being brought to the Emergency Ward by her children, and unfortunately—the situation was not remedied. This individual expressed an interest in letting people know what the problem was, but this individual was afraid because she could not prove that the children were abusing the older person, and that

she would be subject to penalty of the law for making an accusation she could not prove.

So we looked into the subject. I looked to the Library of Congress and found that there was no data on the subject whatsoever except for some information right here in greater Cleveland, Case Western Reserve and Inter-related Projects had some statistics related to elder abuse. I brought it to the attention of my chairman, Claude Pepper, and he said, "Well, we should do a study on this."

What happened was we did do a study and the study was completed in 1980 on the whole subject of elder abuse. It was the first such national study in the history of this country, but the problem had existed for generations and unfortunately this problem was and is swept under the rug by many, many people.

The fact is that that 1981 report entitled, "Elder Abuse An Examination of a Hidden Problem," documented the committee's tragic findings that over a million individuals, Americans, are physically, financially and emotionally abused by relatives or loved ones or sometimes other care givers, but essentially it is family members very often who are the victimizers.

Since that time well over a decade since that document was produced, we have found that there has been unfortunately a dramatic 50 percent increase in elder abuse in a decade. And so now we have last year, for example, 140,000 abuse problems that were reported which was a 10 percent increase over 1987 in elder abuse.

In Ohio, there were last year reports of 9,588 cases of elder abuse which was a 16.9 percent increase over the previous year. And the key is that those are only the cases that are reported. It is very, very difficult when you are victimized to report these things. And while we have things done on a State level, we do not have the kind of bill that I have introduced for the last decade comprehensively passed. We have done piecemeal approaches. I was delighted that they put in some seed money for States which is part of my bill in the last Congress and States will get incentives because of that.

What I want to do is have to a comprehensive bill passed and our report endorses the bill, many organizations have endorsed the bill. It is H.R. 220, the Elder Abuse Prevention, Education and Treatment Act. And basically what the bill does is propose that there be an establishment of a national center on elder abuse under HHS that would compile, publish and disseminate information and programs and special problems related to elder abuse.

In other words, we want the same kind of national clearing house for elder abuse that we have for child abuse. And we have found that this is very, very helpful when we address this as a national problem.

The second thing we want to do is we want to provide State grants, incentives to States that really want to help their people. We know that one branch of government cannot do it alone, but we feel that the States who have programs should be rewarded, so there would be a $10 million price tag for granting States some incentives. That is very little money in relationship to other things that we do in this country.

And the third thing is that we want to grant immunity on a national level for people who report elder abuse. Lots of times care

givers and others are aware of the problem or neighbors are aware of the problem and they are afraid to get involved because they cannot prove it, but they know instinctively that something is wrong there. And there are other aspects of the bill.

But our report which is available in the back if any of you want it, "Elder Abuse: A Decade of Shame and Inaction," that now shows that 1 out of 20 older people are victimized and it includes a special section on Ohio, by the way. We are delighted that so many have helped us. It is in the back. If any of you want a copy, we are happy to let you have it.

Finally, let me just say this. People say, "Well, why do family members abuse their loved ones?" And the number one problem is that the family members are victims, themselves, of alcohol and drugs. And let's not leave out alcohol, by the way. Everyone talks about criminal illegal drugs. Well, I think we are ignoring the problem of alcoholism as well in this country. That is the number one part of the report. And the second reason beyond the fact that people sometimes are just cruel is the fact that in our country we do not have comprehensive ways to help our health care givers do a good job.

Most of the people who are older Americans, particularly vulnerable older Americans, are cared for at home and we still do not have long-term care in this country, we do not have comprehensive health care in this country to assist families so that they can care for their loved ones. And that is why I feel very strongly about national health insurance and long-term care and I am really going to make that one of my personal issues this year.

Thank you. I want to thank everyone responsible. I will do that a the end of the hearing, but most of all I want to thank Congressman Gillmor and people at Lutheran Hospitals, particularly if you do not mind my saying so, the witnesses who have been victimized which is very difficult for them. It is humiliating for a loved one to talk about their kids who have abused them. That is another reason why it is not always reported. And I really want to thank our victims. Those who, for one reason or another, do not want their identities known, they will be testifying behind the screen. Thank all of you very much for being here and all of our witnesses.

I would like to yield now to my colleague and friend, Congressman Gillmor.

[The prepared statement of Ms. Oakar follows:]

Statement of Representative Mary Rose Oakar
before the
House Select Aging Committee
Subcommittee on Health and Long-term Care
ELDER ABUSE: The Ohio Perspective and Federal Solutions
December 10, 1990

I would like to open my remarks today by extending a warm welcome to everyone who is here. The subject matter on today's agenda and the testimony presented will shock the senses. Today we will bear witness to extremely personal accounts of an evil that shatters the very foundation of the family values that are central to our American culture. But that is precisely why these stories must be told, and that is why I want to personally thank all of the witnesses before us today -- especially those who come before us from a personal perspective -- I commend your courage. You may be assured that your willingness to come forward will help spare many others a great deal of pain and hardship.

I must also extend my sincere appreciation to my colleague from Port Clinton, Ohio, Congressman Gillmor, whose deep concern for older Ohioans and older Americans is evident by his presence here today. I must also thank Chairman Roybal of the House Aging Committee whose active support of my efforts in this regard makes this hearing a reality. Finally, I would like to thank those of you here in the audience today. Some of the things that you will hear and see will be extremely upsetting, but hopefully many of you will come away with some new knowledge about what to do if ever, God forbid, you should encounter a case of elder abuse or

neglect.

Last May, the House Aging Subcommittee on Health and Long-Term Care released its latest report, Elder Abuse: A Decade of Shame and Inaction, on the status of State and Federal efforts to confront the scandalous problem of elder abuse in the United States. As the title suggests, the findings of the House Aging Committee's 50 State survey were extremely disturbing.

Since the late Chairman Pepper first coined the term for this national disgrace in 1978, very little federal assistance has gone to the states in their efforts to identify and prevent such abuse or assist victims of elder abuse. The report found that 1.5 million (1 in 20) older Americans fell prey to severe abuse or neglect in 1988 -- a 50 percent increase over the findings of the Committee's landmark 1980 study. Most elder abuse occurs in the home and is committed by family members. 40 percent of all reported abuse in the U.S. is adult abuse -- 70 percent of adult abuse is elder abuse. Most of the abused are dependent upon their abusers, and many fear reprisal or merely cannot overcome their instinctive love for their children to turn them in.

In 1980, I joined forces with Senator Pepper by introducing legislation intended to set up a National Center on Elder Abuse. Despite a strong bi-partisan will, and overwhelming support from the States, Congress has repeatedly failed to pass this modest proposal. The Congressional Budget Office estimates the cost of

H.R. 220 to be $10 million when fully phased in, and requires state matching funds, which most states already put up. This center would collect data, conduct research, and disseminate, information on elder abuse. Also H.R. 220 would authorize HHS to award grants for demonstration programs and projects. This is very similar to successful programs to combat child abuse in our nation.

The Aging Committee report, along with adult protective services all across the country, calls for quick passage of H.R. 220. In 1980, this problem was largely unheard of in our country -- only 16 states required mandatory reporting of elder abuse at that time. Since then, 43 states have adopted adult protective services. Still, the incidence of elder abuse has increased.

As Chairman Roybal stated at the May 1st hearing, this problem "confounds the Commandment, 'Honor thy Father and Mother.'" May the findings of this Aging Committee report weigh heavily on the conscience of this Congress and the Administration until we take decisive action to deal head on with this national tragedy.

This year, we saw a major breakthrough with the appropriation of $5.5 million in federal funding to combat elder abuse. This money, $3 million earmarked for elder abuse programs and $2.5 million to aid the State Long-term Care Ombudsmen in responding to elder abuse complaints in institutions, was part of the Labor-HHS Appropriations bill. It's important because it signifies

that we have finally opened the door a crack. But we have a long way to go. In the 102nd Congress, we hope to see the creation of a National Center on Elder Abuse to collect and disseminate information on the problem, and also provide technical support and research data to those who must confront this concern.

We must also address the underlying causes of elder abuse, which includes the lack of access to affordable treatment for mental illness, and alcohol and drug abuse. Also, we must comprehensively address the exorbitant, and increasing cost of health care and long-term care for older Americans, which places an incredible burden on a rapidly growing number of our nation's families.

Witness testimony will include stories of adult children kicking and hitting their parents, attacking them with weapons, stealing their money and possessions, and denying their parent's basic human needs. A medical doctor will also show slides of victims of elder abuse and explain the cases. The lack of meaningful elder abuse programs and funding, coupled with the rapid growth of America's elderly population, is a prescription for even greater disaster than now exists. Elder Abuse will not simply go away, and we must take swift and determined action to deal with this shameful situation.

STATEMENT OF REPRESENTATIVE PAUL E. GILLMOR

Mr. GILLMOR. Thank you very much, Madam Chairman. I appreciate your calling this hearing of the subcommittee to address this very important and what is a growing problem of abuse of the elderly. I also want to commend you on the leadership that you have taken on the issue of elder abuse, not only with this hearing but over a number of years.

I apologize for the fact that I am going to have to leave early today because of other commitments I have in Washington this afternoon. But I know, Madam Chairman, that you are going to be gathering for the record in this hearing the evidence that we need to move forward.

I would also like to express my appreciation to our expert witnesses and in particular to those who appear before us to show their personal experience with abuse. It is only through public awareness of the problem of elder abuse that we can hope to eliminate any further occurrence.

Madam Chairman, this is not a pleasant subject but so far, it is one that will not go away. The population of the United States is shifting. Within 30 years, the proportion of Americans over 65 will increase from 12 percent of the population to 20 percent. And many of us have elderly parents whose care we are concerned about. Also, not one of us can do anything about the fact that we ourselves will be elderly someday and can potentially fall victim to the sort of physical, financial, or emotional abuse we are prepared to hear about this morning.

I am interested in knowing what mechanisms are currently in place in Ohio to identify, to treat and to prevent elder abuse and whether or not they have been successful.

One important aspect of dealing with any problem in the programs is, what is the best way to finance them?

The current proposal calls for 50 percent of the funding from the Federal Government and 50 percent from the States. At some point before this needed program is adopted, we are going to need significant information from the State of Ohio and from other States. First, we are going to need their recommendations on the best way to establish it. And second we are going to have to have an accurate estimate of the cost of carrying out an effective program in this and in other States, including how much State governments can put into the program. In this respect, I note that as the current State administration is leaving office, Ohio is facing a $262 million deficit in the fiscal year ending this coming June. And projections are that that deficit is going to grow to $1.5 billion in the budget period following that.

Unlike the Federal Government, our State Government cannot legally close the fiscal year with a deficit. And that means Ohio within the next few weeks or months is either going to face drastic cuts or a tax increase or a combination of both. In this respect, we need information from Ohio and other States on whether they can participate in the program and, if so, to what extent.

They may also have recommendations on what they think is a fair split of the cost and whether it is 50/50 as now in the proposal or whether it is some other ratio that would make it a more work-

able solution for them. Returning to the overall problem, I suspect that the disgraceful problem of elder abuse is a symptom of the larger problem of our Nation's unpreparedness for dealing with the growth of the aged segment of our population.

I think we need to concern ourselves with the broader picture as well. Are there enough safe, healthy and affordable options for the care of our seniors? Is there adequate training, support and resources for caregivers including family members who care for our aging citizens?

I want to commend Congresswoman Oakar for holding this hearing and for addressing these problems and for her leadership in those issues and I look forward to our coming testimony. Thank you.

Ms. OAKAR. Thank you very much, Congressman.

At this time, I would like to submit for the record, the statement of Congressman Joseph P. Kennedy. Hearing no objections so ordered.

[The prepared statement of Representative Joseph P. Kennedy follows:]

JOSEPH P. KENNEDY II
8TH DISTRICT, MASSACHUSETTS

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## House of Representatives
## Washington, DC 20515

STATEMENT OF
CONGRESSMAN JOSEPH P. KENNEDY II
SELECT COMMITTEE ON AGING
DECEMBER 10, 1990
CLEVELAND, OHIO

The subject of the hearing today -- elder abuse -- is alien to the American ideal. But the reality is that over 1.5 million or 5% of the elderly population is abused by their loved ones annually. These cases range from adult children physically assaulting their parents, forcing them to turn over their retirement checks and shamelessly neglecting their basic rights. The author Pearl S. Buck wisely wrote, "Somehow our society must make it right and possible for old people not to fear the young or be deserted by them, for the test of a civilization is in the way that it cares for its helpless members." If the test of a civilization is in the way that it cares for its helpless members, I'm afraid this nation is failing that test. Elder abuse has risen 50% since 1980. Since 1980, the primary source of federal funding for elder abuse prevention, detection and treatment, the social services block grant, has been cut nearly two-thirds by direct cuts and inflation. Faced with the need to do more, the federal government is doing less.

We can all work together to end elder abuse. There is a role for the federal government, for each state and for each of us as individuals to play in stopping this terrible tragedy.

First, for the federal government, our role is clear. Let me just say that twelve years ago, the very first fedeal hearing and investigation on elder abuse was launched in the city of Boston by the late Senator Claude Pepper. Twelve years ago, the committee recommended that the federal government pattern elder abuse legislation after the successful federal Child Abuse Act. Twelve years has passed, and still no action.

I do have some encouraging news. This year, the Appropriations Committee allocated approximately $6 million, for elderly protective services and an expanded ombudsman program. This funding, while minimal, represents the first federal appropriation for elderly protective services since this problem was identified 12 years ago.

I feel that it is also the federal government role's to enact long-term health care insurance. There are too many financially-strapped families in this country who are caught caring for their aging parent, balancing a full-time job and raising young children. These kinds of conditions are a guaranteed recipe for extreme stress that neither is fair to the caregivers nor to their elderly parents. Long-term care insurance will ease this burden.

The state governments also have a clear mandate to end the national disgrace we call elder abuse. I'm sure that the witnesses today will verify the need for more state funds to prosecute elder abuse cases. I'm sure that experts will also attest to the undeniable need for preventive measures such as affordable housing, health care, legal support and counseling services.

And finally, there is a role for each of us as individuals to play, and that is, not to turn our back on this ugly problem. We can all take the time to call on elderly neighbors and relatives more often. We can offer to give a hand a couple hours here and there to give caregivers greatly needed time for themselves. There is a role for everyone -- we cannot waste anymore time.

I would like to commend the gentlelady from Chio for holding this field hearing today. Congresswoman Mary Rose Oakar's leadership on the elder abuse issue in Congress is second to none. I fully support her efforts to enact legislation so that we can end this national disgrace called elder abuse.

Ms. OAKAR. Now we will start with our first panel who are victims of elder abuse and their advocates, some of whom are family members. Our first witness is "Mrs. Kelly." I am giving fictitious names for some of the witnesses just so you know. So "Mrs. Kelly," in quotation marks, age 63, victim of financial and verbal abuse by her son, accompanied from Ohio by Ms. Patricia Jarrett, a Lake County Department of Human Services, Painesville, Ohio. She is sitting down here; Mrs. Kelly will be behind the screen.

"Mrs. Jones," age 74, victim of physical abuse by her daughter in Cleveland; accompanied by Mr. Christopher Cameron who is a medical Social Work Supervisor of Metro Hospital Medical Center in Cleveland.

"Mrs. Smith," age 74, who is a victim of physical and financial abuse by her grandson, Cleveland; accompanied by Ms. Lynn Weiland, Cuyahoga County Adult Protective Services here in Greater Cleveland.

"Mrs. Harris," age 70, a victim of physical and verbal abuse by her son; accompanied by Mr. David Hoover from the Adult Protective Services worker, Turnbull County in Niles, Ohio.

Ms. Verna Chears who is the daughter of a victim of nursing home abuse, Toledo, Ohio. Ms. Julie Coyle, Director of Catholic Charities, Eastern Region of the Toledo Diocese, Toledo and Dr. Kenneth Chelucci who is Director of Emergency Medicine at Riverside Hospital, Toledo.

We are going to start with the victims first. We want to thank you all for being here. "Mrs. Kelly," would you begin first, please?

STATEMENT OF "MRS. KELLY," CLEVELAND, OH, ACCOMPANIED BY PATRICIA JARRETT, LAKE COUNTY DEPARTMENT OF HUMAN SERVICES, PAINESVILLE, OH

Mrs. KELLY. Good morning, Madam Chairman, and Members of the subcommittee. I am 63 years old and my husband and I were victims of elder abuse by a family member. I have agreed to join with Pat Jarrett from Lake County Human Services to tell you that story. I am here to emphasize that this problem occurs everywhere including rural, relatively affluent areas such as the area in which I live.

The perpetrator of the abuse which I was afflicted with was my son. My son has lived with us except for the duration of his two marriages. He has floated from job to job or been on unemployment since high school. Although he lived at home, he did not help with the yard work and after a divorce from his first wife, he went to pieces and was psychiatrically hospitalized. We worked with him through this crisis with the help of a mental health agency.

Since that time, my husband and I had been continuously intimidated in our own home by my son's behavior. He would turn the T.V. and radio off when my husband was listening to it, as he felt it was too loud. When my husband would turn it back on, he would grab my husband by the arms and push him away, cussing and screaming at me when I got upset.

This occurred continuously. During the afternoons he spent at home, we were forced to leave our home spending time in local restaurants because we were afraid of what he was going to do and

felt so tense around him. My son struck me several times over the years, although the intimidation was the hardest to live with. At times, he would unplug and hide the T.V. and radio so we could not use them.

I was unable to count on support from my husband in dealing with my son as you see my husband has been diagnosed with an Alzheimer's type disease, having a slight deterioration of the brain. About 6 months before my involvement with Human Services, I noticed some confusion and forgetfulness on the part of my husband. At first I thought he was playing games. It was not until the social worker came to my house and encouraged me and my husband to get physicals that this illness was diagnosed. Neither of us had been to a doctor in years. At the time of my exam, I was found to have bad cells in my uterus. Subsequently, I had a hysterectomy and so far everything is clear.

It was also my social worker who encouraged me to do something about getting my son out of the home. After I made the decision to follow through, my son reacted violently when he overheard me discussing this with my husband. He broke the glass in the upper part of our dutch doors, carrying the top of the door out of my home while calling me rotten names and pushing me out of the way. My son has not returned home since as he now lives in an apartment. Although we just recently initiated contact with him, I think he knows he can never return home to live with us.

Although there is no cure for my husband's problem, at least now I know what we are dealing with and we can live in peace again in our home. Thank you.

Ms. OAKAR. Have you finished, "Mrs. Kelly"?

Mrs. KELLY. Yes.

[The prepared statement of Ms. Patricia Jerrett follows:]

TESTIMONY OF PATRICIA JARRETT
ASSISTANT DIRECTOR
LAKE COUNTY DEPARTMENT OF HUMAN SERVICES

Good Morning, Madam Chairman and members of the sub-committee.

I am assistant director of the Department of Human Services in Lake County, a county whose population is 215,000 and is located directly east of Cleveland. I am here to testify regarding abuse, neglect, and exploitation of the elderly as the problem exists in our area. The western half of our county is part of the Cleveland major metropolitan area while the eastern portion is very rural. We have the third highest per capita income in the state.

While our county does not face the severe poverty issues one sees in the inner city, many other factors contribute to this social problem. In 1989 we received 227 adult protective reports. This is a 90% increase from 1985. Most of the cases we see involve women over the age of 75; and their financial situation is a far cry from the two-career couples, whose income drives the per capita rating of our county.

The testimony of Mrs. Kelly exemplifies two factors which we see often in these cases: mental illness or other mental incapacitation of the perpetrator and dependence of the perpetrator upon the victim for housing or financial support.

Just looking at these two factors and projections regarding the demographic shift, we can expect the problem of elder abuse, neglect and exploitation to compound. Human service agencies have seen an explosion of dysfunctional young families in the last decade. These families and individuals are our caregivers of tomorrow. Unable now to provide for their own needs and the needs of their nuclear families, we can predict they will be unable to provide assistance for their elderly family members in the future.

The changing family structure of even emotionally healthy families will affect their ability to provide assistance to elderly parents.

I grew up in a small coal mining town in Pennsylvania where large extended families lived nearby. My mother, an "at home mom", but also a registered nurse, brought three elderly relatives into our home when they were unable to care for themselves.

I use my personal example to demonstrate what does not typically exist today. Most mothers today are employed outside the home, and many are single parents juggling raising and supporting a family. The time available for caregiving for an elderly family member is restricted. Many families do not physically live in proximity to their elder parents.

In many of our neglect cases, no close family member lives in the community to look after the needs of the elder. Many elders are reluctant to recognize their need for assistance, resulting in self-neglect. Similarly

elder victims are unwilling to admit they are being abused or exploited by a loved one or family member. When the perpetrator is a son or a daughter, a sense of shame and failure as a parent prevents the elder victim from coming forth to ask for assistance.

I would like to share with you a case of exploitation exemplifying this denial.

A 65 year old disabled veteran, I'll call Mr. Johns, came to the attention of our agency due to an eviction proceeding which would have left him homeless. An investigation found Mr. Johns had been giving his checks to a cousin, his live-in caregiver, to pay bills and deposit money to his bank account. Despite the fact he was aware of the eviction, he refused to accept the fact that his cousin had not paid his rent and misused his funds. It wasn't until the worker convinced Mr. Johns to call and verify the balance in his account, did he accept the fact that exploitation occurred. Because we were unable to stop the eviction, Mr. Johns was referred to a Veteran's service for relocation assistance. Before this could occur, Mr. Johns was hospitalized and expired. A will left his possessions to the cousin who exploited him.

Having worked in the area of child abuse for many years, my observation is that adult abuse, neglect, and exploitation is much more hidden. Many elders are confined to their homes and, unlike children who attend school, are not observed on a daily basis by others. That is why it is critical for us to educate those who are most likely to come in contact with elders in recognizing the signs of this social problem. Funding is very limited and as such, non-emergent services such as education and prevention are often neglected. However, the longer a case goes undetected, the greater the pain endured by the elder and the more complex and costly is the treatment.

The typical case we see is usually much more complex than that of Mrs. Kelly. Those elders, however, because of their physical or emotional frailty were unable to testify today. A continuum offering a variety of services is needed as each case is unique in its unmet need. One case of self-neglect may only require the removal of an accumulation of trash from the home and the introduction of a homemaker to maintain a healthy, safe environment for the elder. Others such as the case of a paraplegic wife who repeatedly stabbed her husband with the tip of a knife require more intensive professional services. In this case a hostile/dependent relationship between the couple prevented the husband from protecting himself from the abuse. Intensive home-based psychotherapy would be the treatment necessary in this situation.

In a community such as ours, we do not have the great magnitude of services one finds in a large metropolitan area which can respond to a variety of needs. In many cases, funds coming to our agency are based on formulas which weigh heavily on the poverty factor as opposed to population. When problems such as elder abuse do not relate directly to poverty, counties such as ours get short changed.

It is necessary to realize that what is the "ideal" and has been tradition in the past, family members caring for their elders, is not always practical or available today. Just as "day care" is a necessary institution today for children, elder care must be made a priority. The federal government must lead the way to develop alternatives which provide the resources to alleviate and prevent the abuse, neglect, and exploitation that is occurring to our elders.

I appeal to this subcommittee to support HB 220 as a step to address these issues. We are all aware of the crisis in child protection which occurred in this last decade as we were unprepared to deal with the challenges provided in this area. Let us learn from this experience and avoid a national tragedy with our elders.

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Ms. OAKAR. Thank you very much. We are going to ask some questions in a few minutes, but we will go ahead with the next witness and other witnesses first.

"Mrs. Jones," you have been abused by your daughter. Would you please tell us about it?

**STATEMENT OF "MRS. JONES," ACCOMPANIED BY CHRISTOPHER CAMERON, MEDICAL SOCIAL WORK SUPERVISOR, METRO HOSPITAL MEDICAL CENTER, CLEVELAND, OH**

Mrs. JONES. Yes. Good morning.

Because this is a difficult subject to talk about, I have asked to speak from behind the screen. I am also going to keep my name confidential because I do not want to bring attention to my family. This is such a hard thing to have happened.

I am 74 years old. I have two married sons and a daughter. My problem stems from abuse from my daughter—a tragedy as I look back, not only because it hurts physically, but emotionally. It went on too long and I did not know how to stop it. After all, I am the parent, not the child. And I had cared for my daughter for 43 years.

My daughter is not without her attributes. She is bright, does not drink, has high moral standards and she is an attorney. But any attributes have been nearly erased from memory by her extremely irrational and ever so intense fits of rage. She is angry, very angry, at times and I do not know why. She is a perfectionist in her work and she always was in her studies. But at home she contributed very little, that is, in help with housework, or financially. For that I guess I am to blame as I must admit she had never run a washing machine.

Now it all started getting bad the winter of 1987 when I was no longer permitted in her car. She always drove a nice car, replacing them every few years. She told me I was not deserving to ride in her car. She also quit attending all family functions.

Things escalated over the next two years. To highlight, some days I was not allowed out of my chair for many hours. My pills were mixed with cigarette butts and ashes. She started pushing and slapping me. I had to listen to hours of crying and complaining about how unfair life is.

It ended in the winter of 1989 when it got way out of hand. She threatened to shoot me although I never saw a gun at the time. I tried to sneak out the back door. She caught me and started to hit and strangle me. Somehow I pulled her glasses off. I do not know but she slipped or something. I got out of the door and by now my neighbor was out at her door and my daughter could not continue because there was a witness. It was terrible, so I will end the detail here as it is uncomfortable for me. But I am here, so I wish to get my point of fear and discomfort across.

I am here, so I feel lucky, certainly much luckier than any others who probably are still going through it. But I would ask you: Where do you turn? How do you stop it? If you call the police, by the time they get there, she is gone and it takes as long as one-half hour in Cleveland for the police to get there.

If you go to the prosecutors, they require proof in the form of hospital records of multiple severe wounds, or as in my case they will call a mediation hearing that attorneys scoffed at.

With the help of Nancy Duke, Lake County Council on Aging and Patrick, with the Witness Victim program, I took action. Patrick is a kind caring man, and he suggested an attorney to get a civil protection order. This took 8 months. All that time my family, especially my daughter-in-law, pushed in every agency available: Human Resources, Metropolitan Housing, HUD and more. I cannot even remember.

Yes, today, I feel safe, but a senior citizen cannot help himself in a timely fashion. It took a year, even with all the agencies. I certainly needed protection, a place to stay, support, and many hours of other kinds of help. So I repeat my question: Where do you turn if you are a senior citizen and alone?

I strongly urge Congress to do everything possible to fund and further elderly abuse service and help victims of this terrible crime. Thank you.

Ms. OAKAR. Thank you very much for coming and for your poignant testimony.

"Mrs. Smith," age 74, has been abused by her grandson. Would you proceed?

**STATEMENT OF "MRS. SMITH," ACCOMPANIED BY LYNN WEILAND, CUYAHOGA COUNTY ADULT PROTECTIVE SERVICES, CLEVELAND, OH**

Mrs. SMITH. I am "Mrs. Smith," age 74 and a recent stroke victim. I would like to have my social worker read my statement.

Ms. OAKAR. Somebody is going to read your statement, "Mrs. Smith"?

Mrs. SMITH. Yes, ma'am.

Ms. OAKAR. Because you are a stroke victim and it is hard for you to read it. Okay. Lynn Weiland, I believe, is going to read it. Is that correct?

Mrs. SMITH. Yes.

Ms. OAKAR. All right. Thank you very much for agreeing to tell your story; it is not easy for anybody.

Ms. WEILAND. This is her story: "I took my 35-year-old grandson in because he had no money and no place to live. I helped him obtain general assistance benefits and I tried to assist him in finding lodging that he could afford. Even when I found him a place to live, he would not move out. I guess he preferred to use his general assistance benefits on alcohol than rent as he refused to pay me rent or to move out.

Ms. OAKAR. A little slower, Lynn, because we cannot see you and it is harder to digest. Just take it a little slower and a little louder.

Ms. WEILAND. I guess he preferred to use his general assistance benefits on alcohol than rent as he refused to pay me rent or to move out.

On September 11, 1990, I told him he had to leave. I hated to put him out, but I figured he would probably go to a shelter until he got a room, as he had done in the past. He had been drinking and refused to leave. We had words and then he hit me in the head

with a bag of empty wine bottles. Blood squirted from my head everywhere and I screamed. My next door neighbor opened her door to see what was wrong. We were across the hall and in the doorway. My grandson stated, "I didn't hit her, she fell." He ran before the ambulance arrived and has not been back.

I was lucky this time as I did not need stitches. Then years ago, he stabbed me and I had to get stitches. I went to the emergency room where I was treated. The police came to file a report and advised me to contact the prosecutor's office to obtain a temporary protective order.

The social worker in the emergency room told me someone would be out to my home to help me. The social worker made a referral to Witness Victim, which in turn referred the case to Adult Protective Services. Because the referral was not made directly to Adult Protective Services, it was a week before a social worker came out to speak to me. The next day we went down to the prosecutor's office. They asked me why I waited so long to come down to their office. It was difficult to press charges against my grandson. The family had been so upset in the past when I just filed a police report after he stabbed me. I knew they would be upset. I also felt bad for my grandson and wanted him to get the help I knew he needed. You see, he never had a good male role model when he was a boy and his mother was busy working trying to support them.

Prior to stabbing me in the past he had been a victim of rape and assault in Chicago. My grandson has mental health problems. He laughs and talks to people that are not there. I guess he drinks to block out his unhappy life, but it just makes him violent.

After he stabbed me he was admitted for psychological care. This is what I hoped would happen this time. I really did not want to put him in jail, but I hope that the judge will require him to receive rehabilitation. I knew if I did not force him, I would be enabling him and his behavior would not stop.

At first the mediator stated they could not obtain a temporary protective order for me. They stated that, to obtain a temporary protective order, they would have to file domestic violence charges and issue a warrant for his arrest. They stated this could not be done without an address. He was considered homeless, but I knew that this fact would not prevent him from coming back to my home again.

They finally did issue the warrant and a temporary protective order by listing my address as my grandson's address.

I have been fortunate as I have many friends that look out for me. My grandson has not been back. I think he is afraid. I hope he will someday get the help he needs so he will not ever hurt me or anyone else again. I am grateful to all the people who have helped and supported me during this difficult time in my life.

Ms. OAKAR. Thank you very much, "Mrs. Smith."

Our next witness is "Mrs. Harris," who is 70 years and who has been the victim of physical and verbal abuse by her son.

STATEMENT OF "MRS. HARRIS," GERARD, OH, ACCOMPANIED BY DAVID HOOVER, ADULT PROTECTIVE SERVICES, TURNBULL COUNTY, NILES, OH

Mrs. HARRIS. Good morning. For the purposes of today's hearing, I will use the name, "Mrs. Harris." I am from Gerard, Ohio. I am 70 years old and I work part-time as a nurse. I have been a nurse for 40 years.

In addition to working, I have done my best to raise my children—six boys and a girl—the right way.

Ms. OAKAR. "Mrs. Harris," can I ask you, do you mind being on camera? Is that okay?

Mrs. HARRIS. Yes.

Now they are scattered all over the country and have done well in their chosen professions. But we have had some serious problems with my 30-year-old son whom I will call "Ted."

When he was little, Ted was a generous little soul, a nice kid. We never had any trouble. But Ted experienced a run of bad luck a few years ago and his whole personality changed.

He joined the Air Force when he was 18 and after he got out of the service, he settled in Texas. He got married and had a little girl. Then his wife took up with another man and she and my son were divorced. The ex-wife really took Ted to the cleaners. He lost everything and was denied the right to visit his daughter. On top of that, he lost his job as a plant operator for Union Carbide. His whole world fell apart and he was understandably angry. I do not think he ever worked through the anger.

When his money ran out, he moved back home to Ohio with his dad and me. But you know you cannot go back to a home once you have left it. He did not have any friends in Gerard. He had trouble finding work. He started getting really angry to the point that he was out of control.

He would come in our bedroom when my husband and I were asleep, turn on the lights and start berating us. He would use terrible, obscene language which we never used in our home. At other times, he would turn up his radio so loud that we could not sleep or do anything.

He broke dishes a lot in his rage and that was frightening. He once threw a boot so hard that it bent part of a wall. It was like living in a combat zone. He pushed me around at times and once tried to shove me out the door. He tried to choke my husband once and called him all kinds of names. My husband is handicapped and walks with a cane. At one point, Ted got so mad he broke my husband's cane in two.

My son went for counseling at the Veterans Administration but he did not like it and it did not have much effect. Once he tried to jump out of the car on the way over there so he would not have to attend his session.

Because Ted posed such a danger to my husband and me, I finally called Valley Counseling where I hooked up with Dave Hoover. Even though I had been a nurse for years, I had never heard of Adult Protective Services. I was glad to know such a thing existed.

Dave told me that I had no choice but to get my son committed to a hospital. The thought of putting my own child in a psychiatric

facility was very painful, but that is what we did. Later, Ted moved into a group home. Neither place helped much. He is intelligent enough that he would play the game and do what was asked of him—in other words, act "normal" so he could be discharged.

Finally Ted came back to our home and started getting violent again. He had a paper route to make some money and he knocked me down with his large bag of papers, twice. I called the police and filed a domestic violence report. On the day he was supposed to appear in court, Ted hitchhiked back to Texas.

Recently, my husband and I celebrated our 50th anniversary. We wanted all of our children on hand for the occasion so we invited Ted up from Texas. I hoped he might have changed, but he had not. He started yelling at my husband and me and blaming us for all his problems. He had his music roaring again. He drove our car, which was in perfect condition, through town at over 70 miles an hour and according to a mechanic, blew out the engine. The brakes were ruined, too.

My son is homeless now, living in a shelter or wherever he is in Columbus. I do not know what we can do to help him. Professional help has always failed and when we have tried to be supportive he has always turned on us. It is just a tragedy.

A while back, my husband turned to me and said, "If I had to do it all over again, I wouldn't have had children." I hate to say this, but at the worst times with Ted, I have almost felt the same way. We love our children, but we have just about lost our minds over this.

I think there needs to be some serious action to protect the victims of elder abuse and to treat the people who commit this awful crime. I have always been able to take care of myself and my family, but not in this case. Thank you and I would be happy to answer any questions.

Ms. OAKAR. Thank you very much for coming here and telling us your sad story.

Our next witness is Ms. Verna Chears, who is the daughter of a victim.

Do you want to catch your breath? I can go on to the next witness? You came all the way from Toledo. Toledo has done a lot in this area. I am very proud of the work that has been happening all over the State, but there are some pioneers. Judy Coyle is the Director of Catholic Charities, Eastern Region of the Toledo Diocese.

Julie, why do we not go on to you and let you give your testimony?

## STATEMENT OF JULIE COYLE, DIRECTOR, CATHOLIC CHARITIES, EASTERN REGION OF THE TOLEDO DIOCESE, TOLEDO, OH

Ms. COYLE. Thank you, Congresswoman Oakar, for your continued support all these years and it is nice to meet you, Congressman Gillmor.

Ms. OAKAR. Would you use the mike, because they are not going to hear you in the back.

Ms. COYLE. Sure.

I want to thank all the victims especially for coming today because I realize that you have survived. The individuals that Dr. Chelucci, myself and Verna Chears represent today have not.

Dr. Chelucci will show some photographs, as will Verna, of victims who did not manage to get out, or without a neighbor's attention, did not manage to get free.

What I need to express to you today is that the introduction to elder abuse for most health professionals is usually quite dramatic. Emergency departments appear to be the only resource for severely disabled or injured victims of elder abuse. Battered women shelters may exist in some communities, but they usually are not constructed or staffed for victims who have the problems of aging complicating their battering.

The unusual patterns of bruising would be one indicator that should heighten suspicions—also untreated old injuries, suspicious fractures, bitemarks, sexual assault, stab wounds, et cetera. However, other injuries that are often overlooked as a component of elder abuse or neglect are also immediately life threatening. They include dehydration, malnutrition, infections, which would be referred to as sepsis, usually obtained through open wounds—you'll see those in Dr. Chelucci's presentation. Exploitation or the misuse of an elder's funds or assets is another component of the problem of elder abuse that is difficult to recognize on initial health assessment. But an elderly program's money is often a motivator for overburdened, sometimes initially well-meaning caregivers to continue to attempt to care for an elder in the home without regard to their capabilities as caregivers and the needs of the elder. Repeated emergency room visits are a primary indicator that ongoing appropriate medical care is not being sought.

Health professionals must realize that in dealing with elderly patients, they may be the only individuals that have the opportunity to question unusual symptoms or disturbing symptomatology that may indicate a pattern of abuse or neglect. The consequences of not recognizing this problem and formulating some intervention plan are, of course, devastating and often can cause unnecessary suffering and death.

Medical controversies exist with regard to aging problems, which further complicates the role of the health professional. Cost containment seminars far exceed the number of educational programs for individuals interested in obtaining some guidance in the recognition and treatment of elder abuse and neglect.

Osteoporosis complicates the recognition of suspicious fractures in the elderly. Bitemarks are able to be utilized as a tool to actually determine the perpetrator of a human bite; however, professionals need to be educated to the point that they realize that forensic dentists are available and accessible to them.

Education appears to be the first line of defense for the victims of elder abuse, neglect and exploitation. Target groups should include health professionals, law enforcement professionals, social service professionals and the public.

Current reimbursement systems do not provide well for preventive care for common problems of aging. An example would be Medicare which does not pay for anti-pressure devices until there is a stage 3 or 4 decubitus ulcer or pressure sore present. When

people are confined to bed or wheelchairs, there should be an assumption that they are at high risk for developing such sores and need Medicare assistance.

Social systems and law enforcement agencies' responsibilities and resources differ from State to State. This complicates the opportunity to create educational materials that will assist professionals across the country. However, this exacerbates the need for such materials and programs.

As a hospital social worker for 12 years, I have personally been witness to approximately 180 cases of elder abuse, neglect, and exploitation. As a probate court investigator, I have encountered additional cases of elders at risk. And I currently continue in my practice to become aware of problem situations that desperately require immediate intervention.

The hospital cases were perhaps the most frustrating due to the fact that the knowledge and technology exist to prevent most observed injuries. Delays in seeking treatment was a primary contributor in most deaths.

I will never forget the horror I felt as I was referred to each of these patients, their cries of pain when moved, and the smell of rotted flesh. As a society, I strongly suggest we become outraged. I plead with this Congress to act with great speed to combat the far-reaching problem of elder abuse.

Ms. OAKAR. Thank you very much. Verna, would you like to go next?

## STATEMENT OF VERNA CHEARS, TOLEDO, OH

Ms. CHEARS. Good morning. My name is Verna Chears and I am from Toledo, Ohio. My father was a neglected patient in a skilled care nursing home.

Now, the situation that my family and I were in was that the first nursing home he went to, was closed down because the manager got fined for misappropriation of funds. So my father had to be transferred. He was one of those patients that, because of his illness, had to go to a skilled care facility that had the professional care that he needed. At that time, because of the closing down of this facility, they had to send him 105 miles away. Well, that caused hardship with my family. The facility was well kept and very good, but the problem was that my mother did not drive and we were all used to seeing my father on a daily basis. So we had him transferred back here and that is when our nightmare began. That is when we learned so much about neglect and abuse of the elderly.

My father wound up with sores from his head to his toe. He was malnourished. He wound up with—he had a tube feeder in him because he was not able to feed himself and that was infected all the way around. The slides will probably indicate more as I talk on.

One of the problems that I do see is that I think that families could be better prepared for situations like we were in. In other words, I think that we need something like a residential advocate at a nursing home who would pay particular attention to just the family members themselves. This would help the families deal with

the problems and teach them to look for things like those we did not know to look for.

There were times that we went to see my father when the surface was all clean and had we known to look underneath the cover, period—

Ms. OAKAR. Is this your father?

Ms. CHEARS. That is my father. That is the stomach area where the D-tube goes. And what had happened in that particular case is the food that was to go into the D-tube was seeping out of the D-tube. Nobody ever changed it or anything. It wound up getting infected all around his stomach area. The D-tube itself had caused so much damage to him where it was loose and it was just like hanging back and forth. Pus and everything was all around it, so it was really badly infected.

The other thing is that I think, in the situation like we were in, had we had some type of support group, somebody to come and let us know that these things can happen we would have been better off. If there was someone to show us what to look for, we could prevent these things from happening.

I know that my father and all my family, when we put him in that type of facility, we expected these professionals to do the best they could. But what I found was that once the elderly have had a stroke or a heart attack or whatever leaves them without their full capacity, what happens is that these professionals treat them as null and void. They just put them aside. They say there is nothing medically that they can do for them so they do absolutely nothing. That is the reason my father wound up with the type of sores that he had. And I think that something should be done about it. And I think also that more time should be spent with the family so they can look for these type of things and maybe become aware that these things do happen. I think it should be publicized more that these things can happen to the elderly especially those that are not able to get up and walk around and do the things that they normally would do.

In this case, my father had a stroke, yes, and that was unavoidable. But I believe that the sores could have been avoided. I think if these people, in these skilled care facilities, had more sense of compassion for the elderly and other people who are in that type of situation, it would make a difference. I think we should start looking at our consciences rather than everything else. If these skilled workers could just see the person in that situation, they would do more than just treat him like he is nothing, like you cannot do anything for him.

[The prepared statement of Ms. Chears follows:]

STATEMENT OF VERNA CHEARS
TOLEDO, OHIO

Good morning. My name is Verna Chears and I'm from Toledo, Ohio. I'm here to tell you about the neglect of my father in a nursing home, and to show you pictures of what he went through.

In January 1988, my father had a stroke which left him paralyzed on one side. His mobility was limited, and after a while it got to the point he couldn't swallow food. He went into an extended care facility in Toledo and had a feeding tube put in.

My mother and I thought we could rest easy, but shortly after, the home was closed down and the owner indicted for misappropriation of funds. Because he needed skilled care, my father was one of the last ones moved. In March of 1989, the State Attorney General's office sent him to a facility 105 miles from Toledo. It was a great place, with caring people and a pleasant atmosphere. I thought my father was showing signs of improvement. On his 75th birthday, we had a big party in his room with decorations and the whole bit. He seemed alert and responsive. We had a great time.

As you might imagine, my mother didn't like having my father living 105 miles away, so she'd put his name on waiting lists for several nursing homes in Toledo. In January, 1989, a vacancy came up in Toledo and he moved into a home there. That's when our nightmare began.

I consider myself a fairly knowledgeable individual. I like to think I have common sense and can figure out when something's right or wrong. But I had no idea the kinds of things that go on in nursing homes -- the kinds of things that, unfortunately, were going to happen to my father.

I mean, I thought when a person in this country went to something called a "skilled nursing facility," he or she would receive skilled care delivered by caring people in a safe, comfortable setting. I mean after all, the people working there are professionals, right? They should know what they're doing.

Five days after my father entered the skilled facility in Toledo, he was sent to Riverside Hospital with pneumonia. I thought maybe he'd caught it because of the stress of being moved from one place to another. Anyway, he was very ill.

In April of 1989, my mother was visiting my father and noticed he had had a bowel movement in bed and nobody had come around to change him. Nobody was ever around to do anything.

I was shocked at how infrequently my father was seen by doctors. The doctor came in about once a month and then, hardly did anything. I never even met him. He'd just sign off on all forms given to him by the nurse, who'd just sign on on everything given to her by the nurse's aides. And the aides weren't even certified.

My father died September 20, 1989, just months after entering that nursing home. He had terrible decubitus ulcers -- bedsores -- which I'd like to show you on these slides. We never knew he had them because he was covered up. And again, maybe my mother and I were too trusting that the home would provide good care.

My father lost weight in the home and eventually seemed to lose almost all consciousness. He was always tired and groggy -- I think he felt lost in that home. My mother and I shaved him, cut his hair, fed him sometimes and generally tried to care for him. I'd hate to think how bad things might have been if we hadn't tried to do those things. His mouth was dry -- apparently they didn't give him fluids. And they didn't even brush his teeth.

I visited an elderly lady, a friend of mine, in another wing of the same home one time. Her roommate, who had mental problems, could not feed herself so an aide had to do the job. The aide stuffed three gigantic spoonfuls in the poor woman's mouth in no time and all and didn't pare at all that she almost choked her. Then the aide and several others turned the woman's TV to the soap operas and sat there watching. They couldn't care less.

My mother and I miss my father every day. The only good thing to come out of this ordeal is that we've learned a lot about nursing homes.

I would suggest a few changes. I would like to see a lot more contact between doctors and nurses and the family members of persons in their care. We hardly knew anything about my father's condition, try as we might to find out. I also wish more effort could be made to train families in finding the right nursing home and then advocating on behalf of their elderly relative. And, I wish that each home had a "residents' advocate," to do nothing but look out for residents' rights and their needs. Someone interested and caring could make such a difference if they worked as a bridge between patients, families and staff and tried to ensure the best possible care.

I could go on for hours about what I think needs to be done to help the elderly but, in the interest of time, I'll stop. I think it's wrong, though, to consider people in nursing homes "null and void" just because they can't do for themselves. That's when they deserve the <u>most</u> help and compassion.

My father, being the Christian that he was, would want me to use his experience in a nursing home to make a difference for someone else. This being the season of giving, I'd like to think my testimony and the hearing here today will make a difference -- but it's going to take all of us working together.

Thank you, Congresswoman Oakar, for the opportunity to testify today. I hope that you will continue your efforts to protect and defend people in institutions and at home who are at risk of being abused. Thank you.

Ms. OAKAR. Thank you. We are going to be asking you some questions later. Is your father still living?

Ms. CHEARS. No. No, he is not.

Ms. OAKAR. Dr. Chelucci, do you want to be recognized at this point? Doctor Chelucci is the Director of Emergency Medicine at Riverside Hospital.

I have a nephew who is a doctor who is in emergency medicine right here in the Greater Cleveland, in northeast Ohio. And my nephew has told me terrible stories, just awful, about victims of child abuse, spousal abuse, elderly abuse. It really is a scandal. And it is difficult to treat people—you want to do more than just treat their physical needs, you know. You want to address their psychological needs. It is not easy. Thank you for coming.

## STATEMENT OF DR. KENNETH CHELUCCI, DIRECTOR OF EMERGENCY MEDICINE, RIVERSIDE HOSPITAL, TOLEDO, OH

Dr. CHELUCCI. Thank you, Congresswoman Oakar, and thank you, Congressman Gillmor.

I do have a slide presentation and I hope it does not offend the audience, but I think it is necessary in order to create the impact required to address the problem.

May I have the first slide, please?

Many have questioned society's responsibility in the treatment of elder abuse and neglect victims. If society lacks the resources to provide adequate services to those identified and, as a result, the individual is returned to the insecure setting, is he truly a victim of elder abuse and neglect or in fact a victim of inadequate community resources?

The detection and assessment of elder abuse, even under optimal conditions and by trained personnel, can often be difficult when one's confronted with subtle physical findings and the elder's reluctance to report acts of aggression against them by members of the family or by other caregivers on whom they rely for their basic needs. There often is insufficient information available to construct a clinical profile.

Ms. OAKAR. Are you going to tell us a little bit about each slide?

Dr. CHELUCCI. I would love to, Congresswoman Oakar. They are very detailed cases. This is a gentleman who in fact was being provided with his primary care by family members in the home. He was immobile. He was found to be saturated in feces and urine and adherent to the couch at home. He required 45 minutes for paramedics to literally remove him from the couch prior to transport.

Ms. OAKAR. Do you want to tell them when you want them to move the next slide?

Dr. CHELUCCI. Thank you. May I have the next slide, please?

Very briefly, this is a gentleman who in fact was a nursing home patient and was brought to the emergency department—justifiably so—for evaluation of this little sore on his leg.

To make a long story short, the particular concern is that the history as reflected in the nursing home record and in fact by the patient's private physician suggested that he had been medically evaluated 24 hours prior to this photograph being taken.

The physician who encounters the elderly in his or her own practice is obligated to hold a high index of suspicion particularly in the face of less obvious clinical presentations. This is an eroded—this is the side of a patient's trunk, his chest wall, that was lying up against the bed rail for a prolonged period of time; no movement. The center portion is not terribly clear, but it is exposed rib bone.

Contemporary America is often described as an 11th hour nation and the presence of crisis often stimulates responsible individuals to seek out a solution. In the arena of adult abuse, neglect and exploitation, however, the crisis is of such magnitude that we cannot allow ourselves to sit idly by and hope that the system will absorb the direct effects of the suffering that will without question result from postponing the specific plan of action required.

Those directly involved with provision of health care in our society must undergo an educational process to develop the skills required to detect and specifically identify victims with whom they may be in contact.

The slide that you see before you now is the back side of a gentleman's leg that was slashed. This is the same gentleman who sustained burns to his chest. These were inflicted on him by his alcoholic son when they were involved in a verbal altercation.

Here is an example of—granted this is somewhat more extensive than most— but these are multiple areas of large pressure sores or decubitus ulcers. This was a nursing home patient.

Next slide, please.

Ms. OAKAR. By the way, the Aging Committee came into Ohio and I went with them to some places. We have done an extensive report on nursing homes in Ohio, some of which are run excellently and some of which should be shut down.

Dr. CHELUCCI. You know, while it varies widely from one case to another, the estimated cost of treating these conditions in acute care hospital settings can range from $5,000 to $40,000. And once developed, the bedsores that you saw in the preceding slide require extensive periods of hospitalization and specialized medical care for healing to occur.

The elderly generally require longer hospital stays and are subject to greater suffering and more complications than younger patients as well.

Julie mentioned in her presentation earlier that Medicare and Medicaid at present do not reimburse for the cost of pressure relief devices that would help to prevent bedsores. The cost incurred by the patient or caregiver, therefore, must be absorbed personally and generally ranges from $300 to $500. Unfortunately, many caregivers are reluctant to personally absorb the expense and, as a result, patients are left to progress to active stages of tissue deterioration, for which hospitalization is generally warranted.

It appears clear that current federal reimbursement policies for medical supplies contribute to the failure of domestic caregivers to provide the elderly with necessary preventive devices and, therefore, complications are manifold.

In the past, the practice of general medicine has provided an easy mechanism for practitioners and health care workers to avoid confronting issues of suspected elderly abuse, neglect or exploita-

tion. Old philosophies viewed some symptoms as acceptable, as they regarded age being synonymous with physical deterioration.

Research has proven to us over the past years that many medical conditions in the elderly age group once considered to be inevitable are, in fact, preventable. We have also been shown through exhaustive studies that early identification and management of suspect individuals belonging to high risk groups will in fact ultimately improve quality of life and reduce the cost of health care in our country.

The key to accomplishing this goal is to provide structured caregiver education at both the lay and professional levels. The education of health insurance providers must also be addressed, stressing that prevention is cost-effective.

We have experienced a 50 percent rise in elderly abuse cases over the past decade, yet despite this escalation, the main source of Federal assistance for Adult Protective Services has been cut by nearly one-third. The most recent statistics provided suggest that 5 percent of our elderly population, or an estimated 1.5 million individuals are abused annually. More simply put, 1 out of every 20 elderly persons in this country per year.

Acute care hospital practitioners and ancillary personnel are frequently confronted with suspected victims of abuse. Unfortunately, the majority of these patients who are presented to the hospital setting arrive in a condition of extremis. Despite estimates that only one in eight cases are reported, the staggering in the escalation in the numbers—

Ms. OAKAR. That is an important statistic that has not been stated before at our hearing—one in eight cases are reported. So when you talk about 1.5 million being abused, most of those are not reported.

Dr. CHELUCCI. The unfortunate reality is that the vast majority of these conditions represent advanced medical neglect and may well have been preventable through early intervention. Despite that which the general public wishes to believe, quality preventive medical care is not within the grasp of a good portion of our country.

Ms. OAKAR. What is this slide about? Tell us about this slide.

Dr. CHELUCCI. This is a gentleman, actually insured, relatively well to do, but who was concerned about saving himself a few dollars by not making a physician visit. He had developed a sore on the side of his foot and in very good faith began cleansing it on a daily basis with Comet cleanser.

When he arrived at this condition that you see, he determined that it might have been a little bit beyond his ability. What you see at the center of the foot are maggots.

Now this is a classic example of benign medical neglect. This man thought in fact he was helping himself. And he did not do so. He did—this foot was salvaged, by the way. It was a surprise to most of us, but it was salvaged. But a classic example of a man who had the ability and had the resources, but did not utilize it because of concern over dollars saved.

Earlier Adult Protective Services intervention and identification of high risk indicators can be effective. We cannot anticipate any improvement in the epidemic until Federal resources are used in

combination with committed education to aggressively address the problem. Malnutrition, osteoporosis, and pressure sores are representative conditions that are directly associated or are often responsible for extended hospitalizations, unnecessary pain and suffering, and exorbitant medical costs.

We have the ability to respond successfully and we have the responsibility to respond promptly. The slides I just presented to you are representative of hundreds of similar cases I have personally encountered over the past years. The patients' lesions vary somewhat in appearance from one to another, but the histories and the outcomes are frighteningly similar. Thank you.

[The prepared statement of Dr. Chelucci follows:]

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# ELDER ABUSE, NEGLECT AND EXPLOITATION "WHY WE SHOULD CARE"

Kenneth M. Chelucci, M.D., FACEP
Toledo, Ohio

Many have questioned society's responsibility in the treatment of elder abuse and neglect victims. If society lacks the resources to provide adequate services to those identified and, as a result, the individual is returned to an insecure setting, is he truly a victim of elder abuse and neglect or, in fact, a victim of inadequate community resources?

The detection and assessment of elder abuse, even under optimal conditions and by trained personnel, can often be difficult. When confronted with subtle physical findings and the elder's reluctance to report acts of aggression against them by members of their family or by other caregivers on whom they rely for their basic needs, there often is insufficient information available to construct a clinical profile. The physician who encounters the elderly in his or her practice is obligated to hold a high index of suspicion, particularly in the face of less obvious clinical presentations.

Physical indicators must be utilized as observable conditions of the aged person ranging from medical neglect to blatant physical abuse. Behavioral abnormalities must be carefully analyzed with serial assessments to assist the health professional in identifying the potential for elder abuse. Sudden deterioration of the

elder's condition coupled with caregiving of long duration or lack of assistance, financial or otherwise, from other family members or friends, may represent additional factors in the assessment process. The need exists for concise, empirical assessment instruments that target potential victims.

Contemporary America has often been described as an eleventh-hour nation. The presence of crisis often stimulates responsible individuals to seek out a solution or remedy and often times this approach is ultimately successful. In the arena of adult abuse, neglect and exploitation, however, the crisis is of such great magnitude that we cannot allow ourselves to sit idly by in hopes that "The System" will absorb the direct effects of the suffering that will, without question, result from postponing the specific plan of action required to circumvent what may well be one of the most epidemic and magnus problems to effect our society in history.

Those directly involved with provision of health care in our society must undergo an educational process to develop the skills required to detect and specifically identify victims with whom they may be in contact. This educational process must be extended to the lay public as well through structured programs designed to both teach and monitor caregivers in the home setting.

An action plan can be easily outlined to address the issues surrounding cases of abuse and neglect; implementation, however, cannot be accomplished without the support of government through funding and educational programs.

A very common example of a problem existing among the "neglected" elderly population is the identification and the attendant complications of bedsores. The Institute of Medicine estimates that 40% or 600,000 elderly residents of the nation's extended care facilities are at risk of developing bedsores. The Institute further estimates that each year 60,000 people die from various complications of bedsores. While it varies widely from one case to another, the estimated cost of treating these conditions in an acute-care hospital setting can range from $5,000 to $40,000. Once developed, a bedsore requires extended periods of hospitalizations and specialized medical care for healing to occur. The elderly generally require longer hospital stays, are subject to greater suffering and more complications than younger patients.

At present, Medicare and Medicaid do not reimburse the cost of "pressure-relief devices" that would help to prevent bedsores. The cost incurred by the patient or caregiver, therefore, must be absorbed personally and generally ranges from between $300 -$500. Unfortunately, many caregivers are reluctant to personally absorb

an expenditure of this magnitude and, as a result, patients are left to progress to active stages of tissue deterioration for which hospitalization is generally required. It appears clear that the current federal reimbursement policies for medical supplies contribute to the failure of domestic caregivers to provide the elderly with necessary preventative devices, and therefore complications are manifold.

In the past, the practice of general medicine has provided an easy mechanism for practitioners and health care workers to avoid confronting issues of suspected elderly abuse, neglect or exploitation. Old philosophies were viewed acceptable as they regarded age being synonymous with physical deterioration.

Research has proven to us over the past years that many medical conditions in the elderly age group, once considered to be inevitable, are in fact preventable. We have also been shown through exhaustive studies that the early identification and management of suspect individuals belonging to high-risk groups will, in fact, ultimately improve quality of life and reduce the cost of health care in our country.

The key to accomplishing this goal is to provide structured caregiver education at both the lay and professional levels. The education of health insurance providers must also be addressed

stressing that prevention is cost effective.

We have experienced a 50% rise in elder abuse cases over the past decade; yet, despite this escalation, the main source of federal assistance for adult protective services has been cut by nearly one third. The most recent statistics provided suggest that 5% of the elderly population or an estimated 1.5 million individuals are abused annually. More simply put, one out of every twenty elderly persons in this country fall victim to abuse each year.

Acute care hospital practitioners and ancillary personnel are frequently confronted with suspected victims of abuse. Unfortunately, the majority of those patients who are presented to the hospital setting arrive in a condition of medically serious or critical nature. Despite estimates that only one in eight cases are reported, the staggering escalation in the numbers of identified victims is believed to represent epidemic proportions.

The unfortunate reality is that the vast majority of these conditions represent advanced medical neglect and may well have been preventable through early intervention, education, medical management techniques and an accountable and responsible mechanism of preventive medicine.

Despite that which the general public wishes to believe, quality preventive medical care is not within the grasp of a good portion of our elderly population. Dependency, perceived loyalties to family members or caregivers and a myriad of other factors often delay access to the medical system. The provision of hospitalization or extended care facilities for all is understood to be unrealistic; therefore, the answer appears to lie in the education of caregivers, emphasizing and monitoring their role and responsibilities to prevent any potentially catastrophic outcomes.

The entire country is attuned to skyrocketing medical costs and it has been established repeatedly that the elderly represents the heaviest user segment of health services in this country accounting for an estimated 30% of all hospital discharges, 20% of all private physician visits and further represent one third of the country's personal health care expenditure while constituting only 12% of our population.

Early adult protective services intervention and identification of high-risk indicators can be effective in curtailing a similarly increasing incidence of physical abuse in our country. We cannot anticipate any improvement in this epidemic until federal resources in combination with committed educators aggressively address the problem. Malnutrition, osteoporosis and pressure

sores are representative conditions that are directly associated with or are often responsible for extended acute-care hospitalizations, unnecessary pain and suffering and exorbitant medical costs. We have the ability to respond successfully and the responsibility to respond promptly.

The slides which I have just presented are representative of hundreds of similar cases I have personally encountered over the past years. The patients' lesions vary somewhat in appearance from one to another, but the histories and outcomes are frighteningly similar.

Ms. OAKAR. Thank you, Doctor, and thank you very much, this distinguished panel, for being here.

Let me now ask Congressman Gillmor, who does have to leave in a few minutes, if he would like to ask questions to any of the members of the panel. Mrs. Smith, our stroke victim, was not feeling too well, so she is not here. She had to leave, but everybody else has remained with us.

Paul, before you do that, I want to acknowledge Judge John Donnelly. Where is he? He is the head of our Probate Court which is a very key court related to the subject of elder abuse sometimes. Thank you, your honor, for coming. And Senator Grace Drake, where is Senator Drake? Thank you very much, Senator, for coming here and being here. And I know Madeleine Cain—is Representative Madeleine Cain here yet? I know she has an interest and will be here in a few minutes. We are delighted to have our State representatives and our judicial representatives here today. Thank you so much for coming.

Congressman Gillmor, did you have questions?

Mr. GILLMOR. Thank you, Madam Chairman, and I am delighted to see Senator Drake here. As you have worked on this issue at the Federal level, she has been doing the same thing at the State level.

I want to say I think the panel this morning was excellent. That was very strong, very impressive, very telling testimony. It seems to me, there are a couple of different kinds of cases that we are dealing with. There is the nursing home situation where the person really has no ability to get out of the situation. And we have the other instances where those that testified today have some opportunity of their own volition to get out of it.

I am just wondering, from the people who testified today, in your situations, when you decided you had to get out or you needed help. What was your feeling as to the adequacy of somewhere or somebody to go to and did you think the response and the protection was adequate. What kind of things should we be trying to do to provide more help?

I guess my question is: What happened when you wanted to make a change?

Ms. OAKAR. Do any of the victims want to answer? Behind the screen, I cannot tell. So, Mrs. Kelly, and Mrs. Jones and we have Ms. Chears here, Mrs. Harris. I guess the question is, what happened when you tried to get out of the situation?

Mrs. HARRIS. You feel very threatened and alone. You still do not feel comfortable. You have to do it all by yourself, no matter who is there. And it is frustrating. Recently, my son has called me. He is going to be coming back to our area. I do not know what is going to happen. I hope he does not come home. And there is nothing you can do about the situation. What do you do? How do you protect yourself?

Ms. CHEARS. That is basically my thought also. That is the reason why I felt the need for residential advocates in nursing homes and also a support group which would keep you surrounded with people in the same type of situation that you are in and which gives you that extra support and provides answers to your questions.

As far as I'm concerned, there should be more people hired in these places that will serve just the families so that we would have the extra attention that we need.

Mr. GILLMOR. The people who were victimized and testified, did you know of a place to go or anybody to call? Is there any information?

Mrs. HARRIS. No.

Mr. GILLMOR. There was not.

Ms. OAKAR. How about the people behind the screen? Did you hear the question?

Does anyone want to comment on that—the Congressman wanted to know if these people knew where to go. How did they know where to go? Or do they have any information available to them?

Mrs. KELLY. I am Mrs. Kelly and I got in contact with Human Services. My husband is a smoker, and we were someplace and he told two or three people that I would not give him cigarettes or give him money for cigarettes. Therefore, someone reported it to Human Services. That is how we made the initial contact. At the time I resented it very much, that someone would interfere in our affairs and report them. But when Human Services did come to my home, I later realized it might have been a blessing in disguise because they did help me decide what to do. Going to a doctor and getting a complete physical for both of us was one thing. And like I said, it was over a period of 6 months or so, but I did not really realize that my husband did have this mental problem. But we have been to doctors since then and right now we are working with another doctor to figure out what to do. But also it was good—I could not get any support from my husband in his condition to tell my son to leave. My son always more or less respected my husband and would more or less do what he said, but he would never—very seldom—do what I would say. Almost daily, I would cry and beg my husband to ask my son to leave. Then finally with this great dispute we had, and the breaking of the glass and the door and so forth, my son left and did not come back. And the reason we initiated contact with Pamela is my mother had passed away and I thought I would feel guilty if I did not tell him she had died.

Ms. OAKAR. Did you want to respond, Ms. Jarrett?

Ms. JARRETT. Yes. What I wanted to mention was that in this case, Mrs. Kelly was actually the alleged perpetrator when the report was made to our agency. The report was made in regard to alleged emotional abuse because of her restrictions of cigarettes. However, when we went out to investigate, we found that that was not the case at all. There was emotional and physical abuse of both Mrs. Kelly and her husband by the son in the home. I think we find this in a lot of cases. A lot of times, what stimulates the reports to the agency is not always what exactly is going on in the home. It does require a lot of time spent investigating to get all the facts.

Ms. OAKAR. Mr. Gillmor?

Mr. GILLMOR. As I say, I apologize, but I do have to leave. I wanted to again express my appreciation for this testimony and for your efforts, Madam Chairwoman. And I will be reviewing the later testimony. Thank you very much.

Ms. OAKAR. Thank you very much, Paul. See you soon. And thank you for coming.

Let me ask our witnesses something. I have a profile of typical elder abusers—that they are experiencing great stress usually due to alcoholism, drug addiction, marital problems, long-term financial difficulties. The son of the victim is the most likely abuser, followed by the daughter of the victim. It is apparent that the abused person is often ashamed to admit their child, or loved ones, abuse them and they often fear reprisals.

Can I ask the parents who were abused, was one of the reasons why you just could not get out of the situation the fact that you were embarrassed and humiliated to admit that your child would abuse you?

Mrs. KELLY. Yes.

Ms. OAKAR. Who is that? Can you identify yourself?

Mrs. KELLY. Mrs. Kelly. Yes.

Ms. OAKAR. Tell me a little bit about that, Mrs. Kelly.

Mrs. KELLY. I thought that if I more or less forced my son to leave or demanded that he leave that there would be reprisal. And we changed the locks on our doors when he did leave, at the suggestion of Human Services, because I was afraid he might come into our home when we were sleeping or whatever and try to abuse us.

Ms. OAKAR. But you got help inadvertently by somebody reporting you for—your husband is a victim of Alzheimer's disease, and you got help by Human Services looking into the situation. Then because they were there on sort of a false alarm, they realized you and your husband had been abused. If they had not come to your house, do you think you would have ever gotten help or what would you have done about it?

Mrs. KELLY. I probably would have tried to find out where to go because my husband does not actually have Alzheimer's. It is a type of Alzheimer's that could develop into Alzheimer's. Sometimes it is very hard. I was having this pressure from my husband and my son and I felt like I just could not take much more. So I probably would have eventually gone to some—I would have looked in the Yellow Pages or something to try to find support.

Ms. OAKAR. Is it difficult. Now the fastest growing segment of the population is people over 85. All of you are in your seventies—you are the kids, comparatively speaking. And we have heard testimony that some of the people who are really older have a hard time are finding a way to dial the phone to get help. Were you afraid to seek help? Was anybody afraid? To the people who serve individuals in Protective Services, is one of the reasons that we do not have more reporting that people are afraid that their kid will find out or the person who runs the nursing home will find out?

Did you want to answer that, Ms. Coyle?

Ms. COYLE. Fear of retaliation, if somebody is totally alert and oriented, it is certainly a major problem for us. Even in emergency departments, when the physicians there are a phone call away from Adult Protective Services or the Attorney General's Office, we do not always get the whole story.

Another problem is that we have found that individuals who are slightly confused make poor witnesses. Defense attorneys eat them

up. So we find a fear of even the court process on top of just a fear of the—

Ms. OAKAR. Because if they lose, they are going to be victimized again, right?

Ms. COYLE. Correct.

Ms. OAKAR. If they lose in court because their kid has the sophistication to hire an attorney and because they are not great witnesses due to their fears, it becomes a difficult situation because their child could come back to haunt them. Right?

Ms. COYLE. Right. There is another complicator for the health professional and that is: Where do the reports go? State House Bill 253 and the tremendous efforts of lots of people in Adult Protective Services, and the Office of the Attorney General, have helped in our State. However, it is not very clear-cut for health professionals sometimes in the middle of the night and in ER who should be your first call. State-run facilities prefer that you contact the State Highway Patrol as the first line investigator as opposed to police or sheriff's department personnel. So it gets very complicated when you try to educate down to the point of protocol for individual health care professionals.

Ms. OAKAR. Mrs. Jones, you talked about your daughter who is an attorney who has been victimizing you. What happened to her? Where is she now?

Mrs. JONES. I have not seen her since 1989. We have not spoken. That is the hard part. And I would like to know how to cope with it. I think we need more support groups.

Ms. OAKAR. Do you feel your daughter has mental health problems? What is wrong with her? Or is she just a basically nasty person?

Mrs. JONES. No, basically, she is feeling sorry for herself and she never was bad until she went over the edge because she could not control her own problems. There should be somebody there to help these people, too, and we need more support groups.

Ms. OAKAR. That is what I was going to ask. We are very concerned about the victims, but if the people who are the victimizers, the abusers, could be rehabilitated, we would like to see that happen, too. You would like to see your daughter, would you not, and have a normal relationship with her?

Mrs. JONES. Yes, that is what hurts. I always thought a family means so much and I do not know how to cope with this situation.

Ms. OAKAR. So you feel badly because you cannot see her because you know if you see her, you are going to be victimized, right?

Mrs. JONES. Well, that's probably true. You know, it hurts us. My son feels bad and my family is hurt by this. I do not know how to cope with it or what I did wrong.

Ms. OAKAR. Do you blame yourself—

Mrs. JONES. Well, I think every mother does. And then we had a hard life because my husband died 34 years ago, my daughter was 10, my son was 8. And there never was a father and I was very—I always thought I should work two jobs and I guess that cannot be done.

Ms. OAKAR. So you were the head of your own household raising your kids, like 11 million other women in this country?

Mrs. JONES. But I was overprotective. For 43 years I did everything. I cooked, I washed clothes, I did everything because I thought it was my duty to do it and that is where I made my big mistake. I never asked her help.

Ms. OAKAR. Mrs. Harris, you mentioned something that really struck me. Your husband said that sometimes he has felt that it would have been better for you not to have had children.

Mrs. HARRIS. Now he feels that way.

Ms. OAKAR. But you have other children, right?

Mrs. HARRIS. I have six others, but none of them live in the area. It is my husband and I alone.

Ms. OAKAR. Can you hold the microphone closer?

Mrs. HARRIS. But this son here has broken his heart and he has cried about it. He was going to the State university. He is not allowed to be on the campus for 4 years. He is dangerous there. I am afraid to let him have the car because he was picked up going through the city of Gerard at 80 miles an hour. This was before the accident. In the morning, he would grab the phone and call Dean Sutton of the university and tell him off. He would do all sorts of things. I am afraid he is a danger out there.

He was in Texas for awhile. They broke his nose when he was out there—

Ms. OAKAR. Have you ever tried to get your son help? He obviously has some—

Mrs. HARRIS. Yes, but he is not going to take help. He is not going to do it. And I expect to get a call someday that he has been killed. And I understand that can happen.

Ms. OAKAR. But your other children, do your other children abuse you?

Mrs. HARRIS. No.

Ms. OAKAR. But they are not around to help you.

Mrs. HARRIS. No. And they want nothing to do with him. I am strictly alone in this.

Ms. OAKAR. And you have a fear that someday he may come back. What—

Mrs. HARRIS. I do not know what to do with him. He refuses help.

Ms. OAKAR. Ms. Chears or Ms. Coyle or Doctor Chelucci, what can we do? How can we keep these people away from the elderly? Anything?

Dr. CHELUCCI. If I could respond. This is a tremendous problem. There has been mention in today's presentation a number of times, but it has never been expounded upon, about the probability—and I would like to emphasize that—of the abuser having as part of his character a mental health background or behavior that is out of the norm.

Now it is not emphasized in the literature, unfortunately. When we talk about characteristics of abusers, we talk about alcohol and drugs, we talk about a history of the abuser possibly having been abused himself or herself as a child. Very little is said about mental health status.

A large number of the abusers in the cases I have seen over the years have documented mental health disease that has at one point or another either been treated at an in- or out-patient hospital fa-

cility. A good number of these abusers have in my estimation inappropriate or inadequate out-patient management of their conditions. And it only tends to aggravate the problem. And it may in fact also be in conjunction with an ongoing drug or alcohol problem. There is no place to put them.

Ms. OAKAR. You mentioned one of the abusers was an alcoholic and we have had a number of witnesses who said their kids were alcoholics. And people have said to me, "Why are you having this around Christmas time? You know, who wants to hear about this around Christmas? We all want to feel better during Christmas."

Well, I am having it around this time because I know that the elder abuse is going to be higher during the Christmas season and holiday season when everybody is out having a couple of belts and comes home and lets their parents have it. It may not prevent it in the long term, but it will hopefully give some warning to abusers out there in the short term at least.

Are these people treatable? Is an alcoholic treatable?

Dr. CHELUCCI. They are treatable, but it is not an acute or single process. It has to be ongoing and the support groups that are available—the economics or the financing available—to support the support groups does not exist.

One of the problems that we have frequently is that—and if I might use Mrs. Harris's son as an example—here is a man who sounds as if he has demonstrated potentially violent behavior in the past. He could be arrested. As part of the arresting protocol in most cities or counties, he will be brought to a hospital for evaluation. He will reach the hospital setting and I am citing this as an example because I see it repeatedly everyday.

I will have someone with that history or background come in to me. I will evaluate them. I might in fact "pink slip" them or suggest that he be admitted to a county or a local health facility for emergency commitment for a given period of time and psychiatric evaluation.

I can almost bet my license that within four to six hours they will be back on the street. And these are the type of people that represent a large portion of those that fit the characteristics of abusers that are the cause of the problem that we are addressing today.

Ms. OAKAR. Well, it is no wonder that parents are scared to death about these people coming back to haunt them.

Julie, what do you think we should do? Tell us what to do.

Ms. COYLE. First of all, we want to thank you for the $2.9 million appropriated for education. Education is the first line, the beginning point. We are also far apart in our definitions, I think, of elder abuse and neglect and exploitation. Many people do not think that neglect causes death, but our slides prove neglect did indeed become a large factor in causing death. We need coordination of agencies. In the State of Ohio, we have been fairly successful. As I travel around the country and do some lecturing, I find that that is not always the case.

We need a national clearinghouse, which your bill suggests. Our recommendation would perhaps be that NARCEA, which is a group already formed, should be expanded to include an advisory board complete with dietitians and lots of medical specialists so as to help

a doctor make his or her determination. Doctors do not try to hog that whole arena these days. They like a little help from their friends.

We also need a lot of coordination in terms of changing the way professionals are educated—in general, social work training, nursing training, physician training. As far as money is concerned, dollars from the Federal Government will help States put programs on the map and that is a tremendously needed asset.

The Attorney General's office is very essential in determining prosecution of nursing home abuse and neglect. And that group needs to be tied in in terms of educational arenas.

Ms. OAKAR. Do you think if we had—I feel very strongly about long-term care—home health care services and a long-term care system that didn't make you have to be dirt poor to go into a good nursing home—that is part of the long-term care strategy that I have anyway. But do you think that if we had good services to relieve the stress on the caregiver, that we could help alleviate this problem? We have seen some victims who are victimized by their kids, let's say they have an Alzheimer's parent and the kids never get to go to bed. They are there 24 hours a day. They do not have any respite care for themselves or their loved ones. Lots of institutions will not take Alzheimer's patients, et cetera. They might abuse their parents because of the stress of not getting any help. It is not excusable, but it is understandable when that happens. Do you think our health policy has something to do with this problem?

Ms. COYLE. Absolutely, it is at the core of the problem. A hundred or two more dollars a month to create a terrific situation at home, we cannot have it, but our system will pay $2,500 a month for long-term care in an institution.

Ms. OAKAR. Is it not backwards?

Ms. COYLE. Absolutely.

Ms. OAKAR. Well, you keep testifying, maybe we will hear from you again because we need your help to support some of the legislation that I and others have introduced.

I am proud of Ohio, though, because at least we are one of the 42 States that have an elder abuse program. Vince Cole years ago took my bill—he is still working for HUD, but he was a State senator—he took my bill and introduced it as a State bill. And I think that was the first elder abuse bill that passed statewide. Then others have improved on it, like our senators—Grace has improved on it, and others. So at least we are doing something, but I guess I do not buy the argument that we cannot afford $10 million which is peanuts compared the cost overrun of Defense Department hammers and Desert Shields—just so everybody knows, it is costing $30 billion, you know, in the next few months. I do not buy the fact that we cannot afford to do this.

I appreciate your applause. But I will tell you something: I introduced this legislation with Claude Pepper 10 years ago and we are just getting some of it passed. I feel almost like a failure, you know, because I have not been able to get my colleagues or the President to agree with me. But we are getting there, and we do have some $5.2 million to help the States. But we want to call attention to this problem so that everybody can get a chance for assistance.

Ms. Chears, did you want to comment?

Ms. CHEARS. Yes, I did, Congresswoman Oakar.

The one thing I wanted to stress also is the fact that in the institutions, the skilled care facilities, I think there is a need for support groups for staff, because you have people that are witnessing the neglet of patients and scared to say anything for fear they might lose their job. I personally, after what happened to my father, went into that same facility but to a different part of the wing where they did not know me and there were all types of things that I witnessed myself.

Ms. OAKAR. Well, my bill would grant immunity to anybody who accuses someone, and I think on a State level that is also the case. That is very important because a lot of people, like neighbors and friends and health providers and so on, observe these problems, but they are afraid to tell because of fear of being slapped with a lawsuit. If they cannot prove it, they are the ones that become the criminal. So we really think that is an important part of the legislation, both statewide and nationally. And you are right about education as well.

Does anybody else have a comment before we go to the next panel?

A VOICE. I would like to ask a question.

Ms. OAKAR. If I start that now—I would be happy to do that afterwards unless you are related to one of the panelists, because I have another panel. Why do you not state it?

VOICE. My question was what point should we alert the law enforcement in the community to look at these situations a little bit better? If you remember, Mrs. Freeman did a survey many years ago about spousal abuse and there was a situation where the law enforcement decided that unless there was somebody bleeding, et cetera, that the police would not help out in these situations. And even the discussion today has brought it right up to the point where the local law enforcement will not be supportive or will not respond in case of the call. So my question is, will we still have that type of response from the police or will this particular thing improve that?

Ms. OAKAR. Let me just briefly answer that. The best program that I know of which I would hope our State would emulate is in Cambridge, Massachusetts. There is a very fine prosecutor there that has instituted a program with training—am I right about it? Do you want to tell them about that, Ms. Coyle?

Ms. COYLE. Scott Harshbager who has just been elected the Attorney General for the State of Massachusetts, started a terrific program through the prosecutor's office. It does assist in offering victims an alternative, not just prosecution, but trying to help do some kind of creative things with—I cannot think of the name—a writ to keep somebody out of your home, kind of a protection order. And he has been very creative and used the prosecutor's office as a clearinghouse in this area to help gather the organizations that can help.

Ms. OAKAR. But there is a need to have the police departments better educated about how to cope with elder abuse because very often they are called upon to be not only the law enforcer but also social worker, et cetera. And that is why we need this national clearinghouse so that everybody is educated about what to do when

a need arises. That is what we are working on and hopefully there will be some solid training programs involved.

I want to thank the witnesses, particularly those who have been victimized, and my friends from Toledo who have done such a great job documenting this work. I think you have just played a real role in adding to our hearing and maybe the President will put my bill in his new budget. I understand there are some rumblings about that, which would be great, and I would be the first one to compliment him if he did. Thank you very much.

Our next witnesses are Ms. Myrtle Muntz, who is the Executive Director, Alcoholism Services of Cleveland; Ms. Barbara Galloway, Associate Director of the Division of Comprehensive Services—please, can I have your attention?—the Division of Comprehensive Services for the Cuyahoga County Department of Human Services in Greater Cleveland; Ms. Erika Taylor, Chief of Adult Services, State of Ohio, Department of Human Services, Columbus Ohio; Ms. Shirley Rhodes, Associate Director of Field Services, Ohio United Way, and Member, Ohio Coalition for Adult Protective Services in Columbus; and Ms. Betsy Houchen, Chief of the Bureau of Adult Care Facilities and Rest Homes, Ohio Department of Health, Columbus, Ohio. Thank you all very much for being here.

Let me ask each of you to take 5 minutes. You can summarize. That would be great. We will put your entire statement or any other documentation you might have in for the record and I thank you very much for coming. Myrtle, we are going to start with you. Thank you very much for being here. Please take the mike.

## STATEMENT OF MYRTLE I. MUNTZ, EXECUTIVE DIRECTOR, ALCOHOLISM SERVICES OF CLEVELAND, INC., CLEVELAND, OH

Ms. MUNTZ. My name is Myrtle Muntz. I am the Executive Director of Alcoholism Services of Cleveland, Inc. And I am very pleased to be here this morning and I appreciate the invitation to speak before you.

Alcoholism Services is a community service organization providing alcohol and drug services.

Ms. OAKAR. Myrtle, just one second. We are not hearing you well and I'd like to have order back off to my left here, as well as in the back of the audience, if you do not mind. This is some very important testimony because we are getting to the root of what the community can do. Myrtle if you would just hold the mike—plant it a little bit right there. Thank you.

Ms. MUNTZ. Alcoholism Services is a community service organization providing alcohol and drug services to greater Cleveland for almost 25 years. In July, ASC began a new service directed to older women who are chemically dependent or who are living in an environment where chemical dependency exists. We have a keen interest in elder abuse and would like to commend Congresswoman Oakar and her colleagues for calling this hearing.

One of the obstacles to identifying problems of any kind in the elderly is their lack of visibility. Often, they are no longer a part of the mainstream. When a problem that would generally be covered up in any segment of the population such as abuse, neglect or exploitation exists with an older person, the high risk potential is

multiplied many times over. Elder abuse has received very little professional attention to date due to a lack of public awareness and a lack of adequate resources to provide detection, intervention, treatment and follow-up protective services.

Elder abuse occurs far more often than imaginable. Studies, and we have seen evidence of that here this morning, studies and statistics to date are incomplete and estimate far fewer abuse cases than reality dictates. Our own Alcoholism Services of Cleveland 24-hour phone line receives numerous calls about the elderly and often calls where older parents of chemically dependent adults are being exploited.

Elders who choose to remain in their own homes are isolated, lonely and often severely depressed. Elders seeking a place of comfort and refuge in the homes of loved ones are too often only subject to an environment of punishment, shame and fear. Approximately 5 percent of older adults are abused and approximately 1 percent of incidents are reported. And we heard other testimony this morning that that may even be higher. Most victims of abuse are women over the age of 75.

Four major areas of abuse related to alcoholism are identified. They include physical abuse, psychological abuse, neglect and financial exploitation. Neglect is the area that contains the wider potential because it includes both neglect by caregivers as well as neglect of self. Self-neglect is the cause of almost 44 percent of abuse cases reported. Abuse cases reported with neglect by caregivers accounts for just over one-third. Sadly, the majority of caregivers who are perpetrators of abuse are members of the victim's family.

An area of vital concern that highly impacts all areas of elder abuse and potential abuse is alcoholism. Alcoholism and addiction to other mood-altering chemicals may be attributed to the older person, his or her family members or other caregivers. For example, we know the typical hazards of growing older, such as lapses in memory, joint stiffness, changes in blood pressure and heart functioning, insomnia, brittle bones and a decrease in sensual acuity, which are all part of the physiological changes that normally occur. Add alcoholism or addiction to other drugs or alcohol abuse to the aging process and not only is there more significant physical deterioration, but the mental and emotional functioning is also greatly impaired. The potential for more critical aspects of self-neglect becomes more glaringly evident.

An older person who abuses alcohol is much more likely to suffer from malnutrition and other poor hygiene habits, become confused, forgetful, suffer the effects of falls and bruises, set accidental fires, lose important documents and fail to pay bills, misuse medications, not answer the door or phone and become depressed enough to consider suicide. The unfortunate part of this scenario is that the older alcoholic is harder to find because hiding is an important part of keeping "the secret".

Two-thirds of older people who are alcoholic are in the category of "early onset" which means they have had alcohol problems most of their adult life and have already experienced significant physical and mental deterioration. They have likely alienated many, if not all, or the significant people in their lives due to many years of al-

coholic behavior. This set of circumstances is a clear set-up for self-neglect or direct abuse from a caregiver.

If two-thirds of the older alcoholic population are early onset, as has been established, the probability that their alcoholism is genetic is much greater than the reactive late onset alcoholic who begins drinking much later in life in response to a traumatic life event.

Ms. OAKAR. So people can acquire that problem because of traumatic events. You see a lot of older people turning to alcohol because of the trauma they are suffering as well. Right?

Ms. MUNTZ. Alcohol and other drugs.

Ms. OAKAR. And other drugs. Okay.

Ms. MUNTZ. Medications as they are called by the elderly.

Because alcoholism runs in families, the possibility of the adult children also suffering from the same disease is greatly increased. The implication is that the family may have been dysfunctional to begin with and may have already experienced physical and emotional abuse and neglect. If family members have not received help for this problem, the cycle which may have been in place for several generations will continue. The drinking or codependent adult child who may have been abused by the older parent as a child may now follow suit. If the abuse is not physical, it may be in the form of emotional abuse set up by threats of bodily harm, threats to leave, withholding prescription medications, threats of institutionalization or a consistent barrage of insults. The older person may be deprived of food, isolated in a small area, deprived of medical help, or stripped of money and property. Untreated adult children of alcoholics are more apt to be emotionally vulnerable under stress, making them high risk for abuse and neglect as caregivers.

Alcoholism in older adults is just beginning to get some recognition and acceptance as an issue that needs much more clarification in areas of detection and treatment. We also cannot excuse the signs and symptoms we see as just part of the aging process. The older excuses of, "They have the right to make their own decisions in their last years" and "They're too old to change" just do not hold up anymore. Health and quality of life are rights we all have. They are especially earned in the later years.

People in the helping professions, caregivers, the older population as well as the public in general need education in all areas dealing with the health and well-being of our elderly and especially in relationship to alcoholism and addiction.

You asked a prior witness what we could do or what you should do. I believe that it is important to focus as you are doing on continuing the education, the training and information of caregivers, integrating these problems into the problems that are being looked at from all of the agencies. For example, recognizing alcoholism and addiction as a significant part of elder abuse and what is going on with the elderly is very important for us to do. We need to begin to work together and across lines of agencies in our attempts to work with these problems. We need to continue to make the Congress aware of these problems as they exist so that appropriate allocations can be made and I commend you on your work on the national health insurance.

Ms. OAKAR. Thank you very much, Myrtle.

Ms. Galloway.

STATEMENT OF BARBARA GALLOWAY, ASSOCIATE DIRECTOR, DIVISION OF COMPREHENSIVE SERVICES, CUYAHOGA COUNTY DEPARTMENT OF HUMAN SERVICES, CLEVELAND, OH

Ms. GALLOWAY. Thank you, Madam Chairman. As associate director with the Cuyahoga County Department of Human Services, I have administrative responsibility for our Adult Protective Services Department, which has the Federal and State mandated responsibility for investigating and remedying reported allegations of neglect, self-neglect and exploitation of senior adults throughout the county.

Many of our senior citizens, who have contributed greatly over the years to the growth and economic stability of this country, now reside in marginal and precarious circumstances.

Even worse, since the implementation of the Adult Protective Services law in 1981, there is continually increasing documentation that many of this same population are victims, victims of abuse, neglect and exploitation by others. Many are so impaired physically, mentally and financially that they chronically and dangerously neglect their own basic needs.

From our records, in 1989, 1,046 elders-at-risk reports were received by our agency; of these reports 947 validated the abuse, neglect or exploitation against elderly citizens. Of these validations, 119 substantiated physical, emotion or verbal abuse, 723 substantiated neglect and almost one-half of these involved serious self-neglect and 105 substantiated financial exploitation.

Beyond the validation of circumstances, our agency must design and implement a plan of services which when delivered removes the risk to the elderly being served. With the removal of the risk, the agency then must put in place appropriate supportive services which: [1] prevent any recurrence of risk behaviors or victimization; and [2] in the least restrictive way possible, allow these elderly persons to maximize their own independence in lifestyle as well as activities of daily living.

The gamut of services required to do this effectively includes, but is not limited to such things as: [1] all types of living arrangements; [2] accessible and affordable medical and mental health care; [3] nutrition services; [4] home maintenance services of all types; [5] transportation options; and [6] counseling.

Although these services exist to some degree within our community, their availability in no way meets the demand or the future demand. The overriding barrier is one of economics—economics based on the abysmal lack of adequate and/or creative funding by the government, as well as foundations and other private sector sources. Often the financial burden falls on the individual senior, whose ability to pay for these services is severely limited.

In light of the contributions that this group has made to our country and considering the vast wealth available to the Nation overall, while we recognize the problems of the Federal deficit and the Federal budget, it is inconceivable to me that by lack of attention and lack of caring we, as a purported "moral" nation, allow and in fact force a significant portion of our senior citizens to exist marginally and to be vulnerable to abuse, neglect, self-neglect and exploitation.

This bill, H.R. 220, speaks directly to these problems. It enables States to establish programs to attract, to train, and to retain professional staff specializing in the various facets of gerontological needs; to enhance direct professional and paraprofessional services to those communities needing such services, but who lack the ability to obtain these; and most importantly, to fund the establishment and the maintenance of special geriatric centers where a broad range of service options can be centralized and from which the provision and tracking of these services can be coordinated and efficiently maximized to the community as a whole.

The end result will be improvement in the quality of life to those served as well as to the entire community.

I will end with a quote. It has been said that, "The true gauge of a country's prosperity is by its treatment of the elderly. Dishonor not the old—eventually we shall be numbered among them."

Thank you.

Ms. OAKAR. Thank you very much.

Ms. Taylor.

STATEMENT OF ERIKA J. TAYLOR, CHIEF, BUREAU OF ADULT SERVICES, OHIO DEPARTMENT OF HUMAN SERVICES, COLUMBUS, OH

Ms. TAYLOR. Good morning, Congresswoman Oakar and colleagues. My name is Erika Taylor. I am the Chief of the Bureau of Adult Services in the Ohio Department of Human Services. I would like to take the opportunity to commend you on your ongoing concerns and tireless effort in pursuing the issue of elder abuse and the protection of the at-risk adult. It has been a long 10 years to get to this point. We welcome this invitation to comment on H.R. 220.

Ohio's Adult Protection Service legislation went into effect on November 1, 1981 and appears in Section 5101.60 of the Ohio Revised Code. The statute requires the county departments of human services to investigate all reports of alleged abuse, neglect and exploitation of individuals 60 and over living in independent living arrangements. Our county departments are mandated to investigate the reports and to the extent of available funds—and I emphasize "available funds"—provide or arrange for the provision of protective services.

Ms. OAKAR. There are not many, are there?

Ms. TAYLOR. No.

Although the Ohio Adult Protective Services statute defines an adult as an individual 60 years of age or older, the county departments of human services do provide voluntary protective services to individuals between the ages of 18 and 59 under the State Social Services Block Grant program.

In Ohio, as in the majority of States, the major funding source for elder abuse or Adult Protective Services is through the Social Services Block Grant or Title XX program. However, we are fortunate in Ohio that, recognizing the growing incidence of elder abuse, the Ohio General Assembly has appropriated State dollars for Adult Protective Services for State Fiscal Year 1991 and 1992. We

are one of the few States where actual State dollars are providing services for the Adult Protective or Elder Abuse victims.

Ms. OAKAR. How much is that? Do you know?

Ms. TAYLOR. It is $2 million annually. Not a large amount, but certainly more than we have had before.

Ms. OAKAR. Yes, it is.

Ms. TAYLOR. Statistically, we see an increase in the number of elder abuse situations. Statewide data for fiscal year 1986 showed 7,050 reports of alleged elder abuse, neglect and/or exploitation were received. This compares to 10,396 reports for State Fiscal Year 1990. And, again, we see that there are many other situations that are not reported for the various reasons that were presented here today.

Demographics show that elder abuse, neglect, and exploitation are found in all segments of our society regardless of gender, marital status or economic situation. The person most likely to be victimized is a female, 70 to 89 years old, living alone, with some health problems. Case records document a steady increase in the number of reports on individuals ranging in age 80 to 89. We have become cognizant of the female caregiver otherwise known as part of the sandwich generation, but we are seeing another group emerging: the "old old" taking care of the "old".

Let me explain. What we see is an increase in the number of elderly parents 70 to 90 years of age who can no longer care for their adult children who may be 40 to 60 years of age. I think some of our witnesses alluded to their elderly children and the problems they are encountering with them, whether it is alcohol, drugs or mental condition.

Ms. OAKAR. So we have 60-year-old kids taking care of 90-year-old parents.

Ms. TAYLOR. And vice versa.

In many cases, these are parents who have devoted their lives to the care of their handicapped or mentally-impaired child and can no longer meet the demands of such caregiving.

Let me take you through several home visits that were made in response to some of the reports. Case 1, we have the report of a hostile son refusing health services for his 89-year old mother.

Upon investigation, what we find is a 56-year-old mentally retarded son with the IQ of a 2-year-old who became very upset when a nurse was attempting to examine his mother's leg.

We find the mother to be an 89-year-old individual suffering from Alzheimer's disease who was in need of medical care, did not know the nurse, had a gangrenous foot and, of course, was screaming as a stranger was touching her leg.

Another report shows a man with a heart condition who did not report for his regular medical appointment. The call came from the physician saying, "Please check on Mr. X."

Upon investigation, the social worker went to the home, heard some crying from within the house, could not gain entrance. With the assistance of the fire department, the facility was entered. The man had suffered a stroke and was blocking the door. His wife, a multiple sclerosis victim, was crawling around on the floor attempting to help him. Human and animal excrements were throughout the entire facility.

Another case, we have a woman who was a diabetic frequently admitted to the hospital. We find upon investigation that the couple was diluting her insulin to save costs.

These are just a few of the cases—

Ms. OAKAR. Could not afford the prescription, right?

Ms. TAYLOR. That is exactly correct.

Ms. OAKAR. That is right.

Ms. TAYLOR. These are just a few of the situations encountered daily by our Adult Protective staff. Congresswoman Mary Rose Oakar, your bill, H.R. 220, brings the issue of elder abuse and Adult Protective Services to the national consciousness. The establishment of a national center on elder abuse and the provision of financial assistance for programs for the prevention, identification, and treatment of elder/adult abuse, neglect and exploitation is essential to the development of a national policy.

The Ohio Department of Human Services has had the opportunity to work closely with the National Aging Resource Center on Elder Abuse, otherwise known as NARCEA. NARCEA was established by a cooperative agreement awarded to the American Public Welfare Association from the United States Department of Health and Human Services. The responsibilities of the center outlined in H.R. 220 are being carried out to some degree by NARCEA. We strongly recommend that NARCEA be designated and funded as the national center on elder abuse, if it can accomplish the following:

[1] Expand the advisory group to engage other disciplines. We find we cannot operate in a vacuum. All individuals must be part of the service and the treatment program.

[2] Establish a formalized network of Adult Protective Services and elder abuse practitioners, planners, and policy makers.

[3] Convene a work group to develop uniform definitions and reporting systems that will lead to accurate national data. We realize that States have different definitions and it becomes extremely difficult to provide national data that is of some significance and meaningful to all.

The majority of adult protective services and elder abuse programs are administered through the departments of human services and the Social Services Block Grant is the major funding source. We recommend that the program be placed under the auspices of the Office of Policy, Planning, and Legislation within the Department of Health and Human Services.

In Section No. 3 of your definitions, we would make some recommendations. That is, [1] the definition of exploitation, the word "caretaker" be changed to "person". Often we find that the individual who is the abuser may not indeed be the caretaker.

Ms. OAKAR. Right. Good recommendation.

Ms. TAYLOR. The provision of services to victims of elder abuse cannot be accomplished in a vacuum. We recognize the need for multidisciplinary needs assessment, service delivery and training. To this end, we in Ohio are in Year 2 of our Ohio Adult Training Program that will provide a comprehensive training for our adult service staff and we hope to be able to expand that as we progress to other disciplines within the State so that we could work more cooperatively with the other departments.

At the State and local level, we interact with the aging network, health professionals, law enforcement, probate court and insist on the client's right to self-determination.

A question was raised previously about the involvement of law enforcement. We find it very beneficial to provide local task forces in which we involve these individuals even before a crisis arises and that way we have identified our specific roles and find the more knowledge we have of each other's responsibilities and abilities, the better we are able to service the individuals who come to forefront.

Again, I would like to thank you for the opportunity to comment and we are encouraged by your continued diligence and ongoing efforts on behalf of the elderly and vulnerable adult population and even though Representative Gillmor is not here, I am certainly pleased to see another member here. Thank you.

[Additional material submitted for the record by Ms. Taylor follows:]

# Ohio Department of Human Services
# FACT SHEET

## Elder Abuse, Neglect, And Exploitation In Ohio

**Facts:**

- 10,396 elderly Ohioans were reported a having been abused, neglected, or exploited during the last twelve months (7/1/89-6/30/90).
- Persons in need of protective services numbered 8,511.
- 2,552 were not in need of protective services, but may well have needed other support services provided through their county departments of human services.
- Those in need of protective services but refusing the service totaled 951.
- The county departments of human services handle abuse/neglect/exploitation reports and must begin an investigation of emergencies within 24 hours of their receipt.
- Each of us has an obligation to help our older relatives, neighbors, and friends understand their options when they are subjected to abuse, neglect or exploitation.
- Social, medical, and mental health care professionals are mandated by law to immediately report suspected abuse, neglect, (including self-neglect) or exploitation to the county department of human services. Also required to report are attorneys, peace officers, senior service providers, coroners, clergymen and professional counselors. Any concerned citizen should report suspected situations of elder abuse, neglect, or exploitation to their county department of human services.

**Adult Protective Services Law** *(Ohio Revised Code 5101.60 - 5101.71)*

Some definitions:

**Abuse** means the infliction upon an adult by himself or others of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.

**Neglect** means the failure of an adult to provide for himself the goods or service necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caretaker to provide such goods or services.

**Exploitation** means the unlawful or improper act of a caretaker using an adult or his resources for monetary or personal benefit, profit or gain.

**Emergency** means that the adult is living in conditions which present a substantial risk or immediate or irreparable physical harm or death to himself or any other person.

**Protective Services** means services provided by the county department of human services or its designated agency to an adult who has been determined by evaluation to require them for the prevention, correction, or discontinuance of an act of as well as conditions resulting from abuse, neglect, or exploitation. Protective services may include, but are not limited to, case work services, medical care, mental health services, legal services, fiscal management, home health care, homemaker services, housing-related services, guardianship services, and placement services as well as the provision of such commodities as food, clothing, and shelter.

FOR MORE INFORMATION ☎ the Bureau of Adult Services at 614-466-0095

# ADULT PROTECTIVE SERVICES

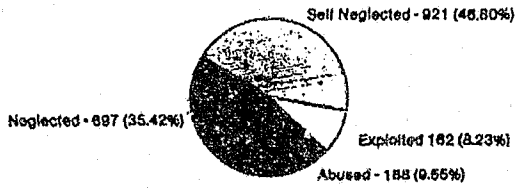
Source: Ohio Department of Human Services – October 1990
Bureau of Adult Services

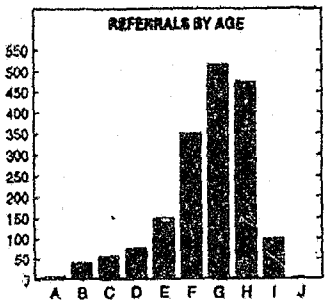
Statistics cover period: 1 January 1990 through 30 June 1990

Referrals: 1,968

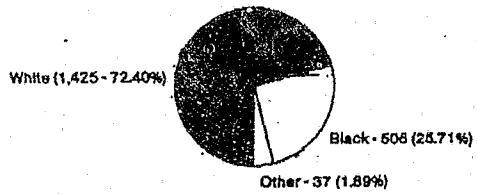
This data represents 1,968 referrals received during the first two quarters of CY'90 by a sample group of 12 urban and rural Ohio county departments of human services.

AT TIME OF REFERRAL
CLIENT WAS REPORTED TO BE



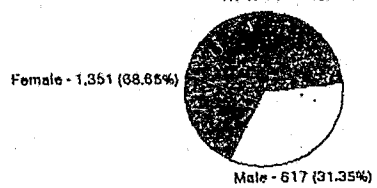

CATEGORIZATION BY RACE
AT TIME OF REFERRAL



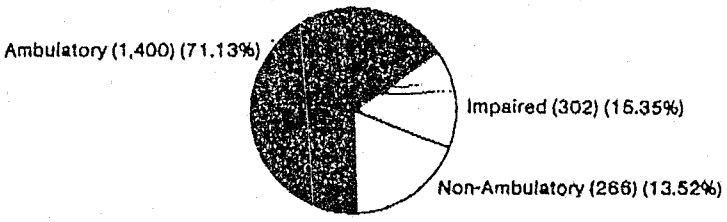

KEY TO CHART

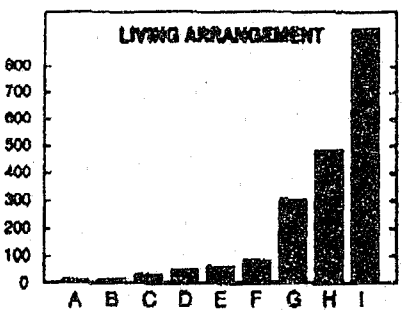
| | | |
|---|---|---|
| Column (A): persons aged 18 through 19 | 2 | ( .15%) |
| Column (B): persons aged 20 through 29 | 30 | ( 1.52%) |
| Column (C): persons aged 30 through 39 | 54 | ( 2.74%) |
| Column (D): persons aged 40 through 49 | 60 | ( 3.04%) |
| Column (E): persons aged 50 through 59 | 150 | ( 7.62%) |
| Column (F): persons aged 60 through 69 | 454 | (23.06%) |
| Column (G): persons aged 70 through 79 | 618 | (31.40%) |
| Column (H): persons aged 80 through 89 | 487 | (24.74%) |
| Column (I): persons aged 90 through 91 | 108 | ( 5.48%) |
| Column (J): persons aged 100 and over | 5 | ( .25%) |

CATEGORIZATION BY SEX
AT TIME OF REFERRAL



CLIENT MOBILITY AT REFERRAL




KEY TO CHART

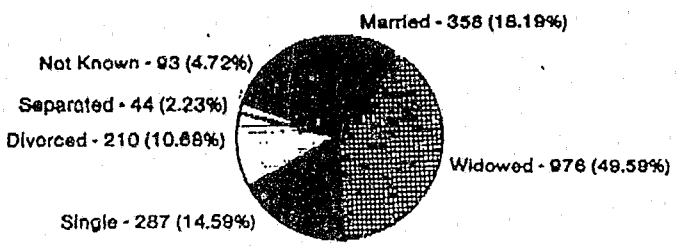
| | | | |
|---|---|---|---|
| | Column (A): persons living in an open shelter | 8 | ( .40%) |
| | Column (B): persons living with a paid caretaker | 14 | ( .72%) |
| ** | Column (C): persons living in a congregate care facility | 22 | ( 1.12%) |
| | Column (D): persons who were displaced | 33 | ( 1.68%) |
| | Column (E): persons living with a friend | 58 | ( 2.94%) |
| * | Column (F): persons living in a medical facility | 63 | ( 3.21%) |
| | Column (G): persons living with their spouse | 318 | (16.16%) |
| | Column (H): persons living with a relative | 489 | (24.84%) |
| | Column (I): persons living alone | 963 | (48.94%) |

Notes:

* Medical facilities category includes convalescent centers, institutions, hospitals, and nursing homes.

** Congregate care facilities category includes boarding homes and group homes.

REFERRALS BY MARITAL STATUS



Ms. OAKAR. Thank you very much, Ms. Taylor.

Well, you know, it only took me 6 years to get mammography coverage in Medicare. But this is a little slower. You cannot give up because we really just have to do something about this problem. It is frustrating for me not to have had my entire bill passed—parts of it that would helped you do your job because you are right in the field, all of you women. And God love you. You know, it is really difficult because you have to face the problem every day. I am just trying to create a policy that would help you do your job better and cure our country of all these terrible diseases.

Ms. Rhodes, thank you for being here.

**STATEMENT OF SHIRLEY RHODES, ASSOCIATE DIRECTOR, FIELD SERVICES, OHIO UNITED WAY, AND MEMBER, OHIO COALITION FOR ADULT PROTECTIVE SERVICES, COLUMBUS, OH**

Ms. RHODES. Thank you, Representative Oakar.

I am here today to offer some testimony on H.R. 220 on behalf of the Ohio Coalition for Adult Protective Services, which I will refer to as the "Coalition" for short.

I have been a member of the Coalition since 1986 since my friend, Erika Taylor, persuaded me to get involved. My work is with the Ohio United Way Office.

Just a brief message about the organization. The Coalition has been in existence for about 7 years. It is a network of individuals and organizations who are concerned about Ohio's abused, neglected, and exploited older adults. Recognizing the need for multidisciplinary assessments and service delivery and the value of networking, several State departments, local public and private agencies and a variety of disciplines came together to form the Ohio Coalition for Adult Protective Services.

The Steering Committee for the Coalition includes representatives from the Ohio Department of Human Services, which now has the chairmanship of that and Erika is the president of that at the moment; the Attorney General's Office; the Ohio State University School of Nursing; Summit County Probate Court; the Ohio Department of Aging; Ohio United Way; a physicians' group; Hamilton, Logan, Summit and Turnbull County Departments of Human Services; Indian Lakes Adult Protective Services Practitioners; Northeast Ohio Adult Protective Services Coalition; and other practitioners. The Coalition has been an advocate for State funding for adult protective services and was instrumental in securing the appropriation of funds for Adult Protective Services in the budget for fiscal year 1990-1991. Erika has also told you the amount that is in that at the present time.

The Coalition also sponsors an annual conference in Ohio on adult protective services. Plans are underway for the sixth such conference to be held in the spring of 1991 and I brought along a copy of our recent newsletter which will give you some idea of our current activities. The pink one here is the flyer on the upcoming conference in 1991.

Ms. OAKAR. We would like to have that. And I hope the audience will come up afterward to get that, because you have a number of copies.

Ms. RHODES. The Coalition welcomes this opportunity to comment on H.R. 220 and is pleased that you are having these hearings in Ohio to provide Ohioans who are not able to get to Washington an opportunity to comment on the bill and to share with you the problems and needs experienced in Ohio.

The Coalition has followed for some time now your efforts, Representative Oakar, to bring national attention to this growing problem of abuse, neglect and exploitation of some of our most vulnerable citizens, the elderly and the disabled.

We support your call for help to bring more Federal resources to bear on the critical issues of identification, prevention, and treatment of abused persons who are elderly and/or disabled. In addition to the Federal financial resources, a strong national effort will also do a lot to bring about a better understanding of the scope of the problem and program that help.

Hopefully, over the coming years, a set of national service performance standards can emerge to better serve this vulnerable population. You will note that in my remarks I have added the disabled as well as the elderly to the list of those who need services. Others may have already spoken to the need for such services not only for the elderly, but for the disabled, physically and mentally as well.

Indeed, much of our homeless problem across the nation has its root in the abuse and neglect of younger as well as older persons who are handicapped either mentally or physically.

Ms. OAKAR. That is a very good point that is seldom raised. Many homeless people are being abused in some way or another beyond their own self-abuse at times.

Ms. RHODES. Direct services and other resources should be expanded to all adults who are vulnerable and exploited. I am not sure if you will hear much testimony here today from younger persons who are primarily disabled, but I have been given to understand by professionals with direct hands-on experience in the field that abuse, neglect and exploitation exists for the disabled as well as the elderly and you may want to give some consideration to expanding the definition of adult to include the age group starting at age 18 or 21 who are abused, neglected and/or exploited in order to focus on the full dimensions of the problems as experienced in many communities across the country.

Ms. OAKAR. That is great advice. I will do that.

Ms. RHODES. Ohio's Adult Protective Services law needs some revision also as it defines adult as persons 60 years of age or older who are handicapped by infirmities of aging or who have a physical or mental impairment which prevents him or her from providing for his own care or protection and resides in an independent living arrangement. And you have heard testimony here that abuse occurs not only in independent living arrangements, but where they are living with others. So we need to do something with our Ohio code to make some changes there.

Ms. OAKAR. That is why I am glad we have State legislators here, too. I think that is good advice as well.

Senator, if you want to come up, you are more than welcome to. Anybody else from the legislature, we are delighted to have you.

Senator DRAKE. Thank you.

Ms. OAKAR. Go ahead, Ms. Rhodes.

Ms. RHODES. Let me say at the onset that the Coalition is very much in support of your efforts to bring Federal resources to bear on this problem. States need financial help to properly identify the scope of the problem and to develop the services to address the problem.

Ohio is a prime example of the need for financial resources in this area. While Ohio has had a law on the books for the protection of abused, neglected and exploited adults since 1981, it was not until this current biennium that state financial resources were made available to counties which are the local entities that are charged with providing protective services for them to do the job.

Ohio, like many other States, were dependent on using Title XX Social Service Block Grant funds for this purpose. Those resources are still significantly under what is actually needed for the counties to do the job.

Ms. OAKAR. That's all Federal money.

Ms. RHODES. Right. That's all Federal money. They are significantly under what is needed for the counties to do the job adequately.

Let me now turn to some aspects of your proposed legislation, H.R. 220, the section on the creation of a national center on elder abuse.

The Ohio Coalition for Adult Protective Services supports the idea of a National Center on Elder Abuse to carry out the six objectives outlined in H.R. 220. Our suggestion is that we need to capitalize on the fine work that has already been accomplished in understanding the scope of the problem and in sorting through the possible solutions which each of the States are presented with. I refer here to the contract with the American Public Welfare Association with the U.S. Department of Health and Human Services. And that is for the National Aging Resource Center on Elder Abuse, NARCEA, that Mrs. Taylor just mentioned.

Rather than create a new structure, we suggest that some language be found to make NARCEA the national center. And, that additional funding be provided to NARCEA to do the job as proposed in the objectives outlined in H.R. 220 for the National Center. NARCEA has already begun such an effort and has a splendid foundation upon which to build.

In addition, the Coalition would also like the definition of adult changed to include disabled persons age 18 or 20, as I have spoken before. This would broaden the focus of needs identification, programs and service for abuse, exploitation and neglect beyond the scope of programs and services for the elderly to identification and caregiving to handicapped and disadvantaged people in general. And it would focus responsibility with Human Services Departments across the Nation, which is what Ohio and some other States have done with their Adult Protective Services legislation.

It also eliminates some of the jurisdictional problems between the Administration on Aging and the Department of Human Services in some State administrations.

In summary, our recommendations are four points:

[1] That the bill should make reporting of elder abuse a Federal requirement for all States so that we can get a full scope of what the needs are and the problems are;

[2] That NARCEA should be named as the National Center and administering body by contract with the Department of Health and Human Services and that sufficient funds should be appropriated to NARCEA for them to perform the functions as delineated in the Act;

[3] Allow sufficient time for NARCEA to accomplish the objectives. We have thrown out the 10 years to do this and stated that there should be a report back by them to the Congress on recommendations for future action; and

[4] Lastly, we feel that there needs to be a major focus on, and resources approriated for, the staff training needs that the States present. This should focus on a multidisciplinary training approach.

Thank you very much.

Ms. OAKAR. Thank you very much for your fine testimony.

Ms. HOUCHEN. Betsy, would you pronounce your last name?

Ms. HOUCHEN. Houchen.

Ms. OAKAR. Houchen. Yes. Yours is a long-time interest in this subject and I am delighted to have you here.

**STATEMENT OF BETSY J. HOUCHEN, CHIEF, BUREAU OF ADULT CARE FACILITIES AND REST HOMES, OHIO DEPARTMENT OF HEALTH, COLUMBUS, OH**

Ms. HOUCHEN. Thank you.

I am very pleased to be here. My name is Betsy Houchen, Chief of the Bureau of Adult Care Facilities and Rest Homes of the Ohio Department of Health. And I am glad to have the opportunity to testify today as a registered nurse and past director of a large home care program and hospice program, I realize the importance of today's topic and I commend you for holding this hearing.

My purpose in being here is twofold. First, I will describe some of the situations that the Ohio Department of Health has found in illegal nursing home settings and second, I will describe how Ohio is addressing these situations through legislation establishing licensure of board and care homes. We now call these board and care homes adult care facilities.

First, I would like to relate some accounts of situations we have encountered.

The resident was sitting in a wheelchair. She was wearing a diaper and the room reeked of urine. Her lower legs were edematous and blue. Her skin looked fragile and small contusions were noted on her arms.

It was reported that the owner is frequently gone from the residence and during her absence, the residents are cared for by her two daughters who are 12 and 13 years of age.

Another account is that authorities shut down a home for the elderly where residents were said to be living on one meal a day and at least one was lying in her own waste. Three bedfast residents were upstairs. One was semi-comatose, tied by her wrists to a bed. She was fed through a tube in her stomach and had bedsores. The

room temperature at 11:00 a.m. was 87 degrees. Another semi-comatose woman was taken to the medical center and treated for dehydration and a urinary tract infection. The owner was charged with 11 misdemeanor charges of patient neglect.

These situations and the need to create viable alternatives to nursing home care, was the impetus to create HB 253, now Chapter 3722 of the Ohio Revised Code, the licensure law for Adult Care Facilities.

It was established as part of Ohio's elder care package and funding for Adult Protective Services was also part of the elder care package. The Ohio Department of Health works cooperatively with human services departments to identify and resolve elder abuse and neglect. The statute became effective November 15th, 1990, and we are currently establishing the rules for regulating the homes. Two types of homes will be licensed: adult family homes with three to five residents and adult group homes with six to sixteen residents. Residents are defined as unrelated adults who receive supervision and personal care services in the home.

In 1988, Governor Richard Celeste, in his State of the State address, identified the need for community-based alternatives to nursing home care as an option for Ohio's elderly. It was recognized that if adult care facilities were to be a safe alternative care setting, basic standards and parameters had to be established through a statewide licensure program. Chapter 3722 of the Ohio Revised Code regulates adult care homes and these will be homes where elderly live, receive accommodations, supervision, personal care services and skilled nursing care for short-term illnesses.

The statute establishes standards and parameters to guide the provision of housing and personal care to older adults. We believe that the majority of homes intend to provide good care, however, standards are needed to provide guidance so that neglect and abuse does not occur.

Furthermore, this law requires that consultation and education is provided so that homes come into compliance with the statute. This also will boost the caregiver's ability to provide safe and quality care. And lastly, the new law establishes that it is a resident's right to be free from abuse, neglect, or exploitation. The statute authorizes the Department of Health and the ombudsman to enter the homes without permission to investigate complaints. The Department of Health will work closely with the ombudsman program and the Attorney General's Office to enforce and assure this right.

As we begin to implement the new law in Ohio, we will learn more about how the law can help prevent abuse and neglect and what additional measures, such as training or respite care for adult care operators may also aid in the prevention of abuse and neglect.

In summary, the Ohio Department of Health supports the Federal initiatives and Representative Oakar's efforts to help States identify and prevent elder abuse and neglect. We also respectfully suggest that Ohio's law may serve as a model for developing home and community-based alternatives to traditional nursing home care.

Again, thank you for providing me this opportunity and I would be happy to answer any questions.

Ms. OAKAR. Thank you very much, Ms. Houchen.

Let me ask my colleague and friend, Senator Drake, if she would like to make any comments before I ask some questions. Senator, if you would like to—it is a partnership. We are trying to do some things federally but we want to give incentives to the State and I know the State has done some things beyond what other States have done. It is never enough, but still you should be congratulated on some of the things that have happened. So would you like to make a statement, Senator?

STATEMENT OF HON. GRACE DRAKE, SENATOR, STATE OF OHIO

Senator DRAKE. Yes. I thank you for holding this meeting today, Representative Oakar, because this is very important. I sat and listened and I am troubled particularly about the in-home care, the private home care. We are trying very hard and the people sitting here as witnesses or who are testifying today have been a very large part of what the State has been doing to try to address those areas that we can address.

As we all know, it is very hard to mandate morality. That is almost impossible. We have looked all summer at the House Bill 822 which is processing compliance, we hope, for the Omnibus Budget Reconciliation Act of 1987. And we are to have that in place by October 1st. We were told that we were not in compliance and that we could wait until right after election to pass that, and that was done. That is really to protect people in nursing home situations and it is what the Federal mandates will be. I do not think all the guidelines are here, so there was some difficulty crafting a bill where the guidelines were not all in place.

I do believe that House Bill 253, which we call the Ombudsman Bill, does give the ombudsman more training and allows him to go in unannounced. I hope that will help in the bad nursing home situations throughout the State.

There are so many good ones, but as the Health Department will tell you, every so often a bad one pops up. We do not want that. I feel that we are tending to the nursing home and the adult care facilities. It is the in-home abuse that bothers me so much. All of it bothers me, but I think that we are addressing those other pieces. And the in-home abuse is pretty difficult to address.

Ms. OAKAR. Thank you very much. I have been through some of the rest homes with the Department on behalf of our Aging Committee, and there are some real problems there. And your description, Betsy, of some of them are things I have seen right here in Cleveland. And I think that new law that has been passed with the implementation of the 1981 authorization I think is really a good step and hopefully, we will be able to see how things can improve and do even more than you already do, Senator, in State efforts. We appreciate the work that you and others do and what the Governor's Office has done, too. I see Mr. Pat Rogers and others in the audience. You have done some nice things that do not get a lot of credit, but I personally appreciate it.

Here we have State and private agencies that represent private contributions, State and Federal funds, and other avenues. And then we have county people here and we have United Appeal rep-

resented which comes to Ohio most of any State in the Union in terms of the generosity of our people. And we have State people who have—how do you—and you have a Federal legislator and a State legislator here. We are missing the law enforcer. How do you coordinate with each other? Do you talk to each other much? You mentioned, Ms. Rhodes, that there is this sort of umbrella group. Is it fragmented, this service?

What could we do to get a one-stop situation or is that impossible for people, because I think part of the frustration is that people just do not know where to go for help. You know? And you may be able to stop one thing but not another. Can anyone address that? Ms. Taylor?

Ms. TAYLOR. I would like to respond partially to that. I think the biggest thing that we have to do is familiarize not only our accounting staff but our private providers, and law enforcement, with the fact that there was such a statute. Although the law was passed with limited funding, it became a two-edged sword: Do you make everyone aware of the service? What are your options? What can you provide? What we have done at the State and local level is encourage the development of coalitions and task forces that would pull in the various disciplines, whether it be health, law enforcement, or human services and attempt to look at the funding sources of those different agencies to see that we could blend in creatively and come up with some type of a service plan.

Now that we do have state funding for adult protective services, we do have some dollars going into each county which were not designated before. So with a little bit of money, we are looking at the training aspect, the public awareness issues of letting people know that the problem does exist and encouraging individuals to report. It is very hard, as people mentioned, to report on the fact that you are being abused and neglected and exploited by your family members. So we are attempting to let people come to the forefront, whether it is voluntary, involuntary, and remain anonymous and try to get all of the disciplines involved.

And the other key is looking at the support services. If we can work on prevention, I think that is most of the battle. If we can look at home health aid, homemakers services, home-delivered meals, that type of activity. And the greatest need that we seem to be looking at is the need for respite. We have very many families who are caring for their elderly or disabled individuals, but to take care of someone for 24 hours a day forever is a very, very difficult thing and we need to look at some type of respite activity at a time away from that caregiving which is very difficult.

Ms. OAKAR. Without the congregate services to help them.

Ms. TAYLOR. That is right.

Ms. OAKAR. Well, that is why we need long-term care and comprehensive long-term care and national insurance in my judgment for accessibility. Because I do not care who the family is, it is hard to take care of an Alzheimer's patient or somebody real sick and fragile and especially since people are living longer. We had in 1968, 3,200 people who were over 100. Today, we have 45,000 over 100. And the fastest growing population are people over 85 and many 85-year-olds are able to do some things for themselves, but

lots are not. And they ought to be able to live a life of dignity, you know.

I was struck by your comment about disability. That is a problem and while Medicare has folded that aspect in, I want you to know that my long-term care bill does not discriminate in terms of age. I feel very sensitive about families who have young people who are disabled as well. Some of the bills say 18 and over. I think it should be everybody.

And I want you to know that while this is a hearing on elder abuse, both the Senator and I, in no way mean to diminish other abuse problems like child abuse and spousal abuse which are also critical problems.

I asked about fragmentation. Ms. Muntz, did you want to say something about that?

Ms. MUNTZ. I wanted to say two things. First of all, I want to answer a question you asked earlier: Is alcoholism treatable? And the answer is yes. I wanted you to have that for the record.

Ms. OAKAR. What are we doing about it? I will tell you what the Federal Government is doing about it: Not much because everyone has talked about illegal drugs, but nobody wants to talk about alcoholism. And I have got to tell you something. I am going to start talking about it. And no matter what the lobbyists say, because they are after me now because I have sponsored some bills related to labeling and things like that. But I think that is such a chronic problem in the country. And you covered, Myrtle, both the abuser who is an alcoholic and drug abuser and the abused. Very often our older people do not want to talk about it, but they take too many drugs and they drink a lot.

Ms. MUNTZ. Exactly. And we are finding older people abusing other older people.

Ms. OAKAR. That is right. And it is not cute no matter what their age. Right? We do not pat people on the back if they are alcoholics.

Ms. MUNTZ. And it does not speak to the quality of life that we know that people can have. Life is better sober. That we know, whether you are whatever age. And so we are working a lot on that. But I do believe we are beginning, just beginning—I think hearings like this are very helpful in crossing over fields of interest, areas of concerns so that we can begin to work together. We have been working a little bit with the Geriatric Education Center in developing a curriculum for training of caregivers in the area of alcoholism and worked with the elderly so that we can begin to get the information out to each other about the fields of interest.

When we entered the area of working with older persons, we discovered that while we knew a lot about alcohol, we did not know very much about elderly. And we needed to get that information from the experts in the area who did. And together to build some curriculum and information. So I think that we should be having these hearings in every State, in every community in the Nation so that we can begin to exchange this information.

Ms. OAKAR. Can you just briefly, or anybody who wants to answer this, talk just quickly about the help available for elderly abused by alcoholics and drug abusers and the help available for elders who are abusing themselves. And therefore become more vulnerable to elder abuse by others and abusing themselves.

Let's say an elder person is an alcoholic who wants to do something about it, what do they do? Where can they go?

Well, the kid is an alcoholic and we heard testimony where the grandson wrapped a woman who later suffered a stroke with wine bottles. What does that say about society?

Ms. MUNTZ. I guess I can only respond based on my current experience and we are in the process of mounting one small project that will respond to calls of that sort. But I believe there is not enough service available to provide services for the frequency of calls that we get for that kind of service.

What you need to do is to get out, to get into the situation, to use the kind of intervention techniques that we have in working in the area of alcoholism, but it takes a lot of worker time. It takes some pretty intensive work with families. And part of what we are finding out now is that our treatment and rehabilitation facilities are not prepared to really serve older persons as they come into those facilities where there is an older alcoholic. So we have got a lot of work to do in this area, from my perspective.

Ms. OAKAR. One of the things I am working on and I would share this with my colleagues on a State level is that I have found that my colleagues in Congress, the Omnibus Drug Act has about $8 billion, 99 percent of it is for what we call illegal drugs. One percent is about alcoholism and 64 percent is for prisons. And nobody wants to talk about treatment and education and what we do with little kids who have these problems, particularly alcoholism which leads to harder drugs and so on. And I, you know, it is really frustrating for me because we are suffering from tremendous lobbying going on. Every time we raise the issue, it is like you are being unpatriotic to your country. And I just think we have to speak out more about the education and treatment and what needs to be done because what I hear you saying is there is no place for these people to go and be dealt with. I mean I just think that is just as much a national security problem as anything we have talked about these days. You know?

The Senator raised the issue about her concern about this being an in-home problem that you almost can deal with more readily with laws and so on. What should we do for the family? What should we do for the abusers? Let's say we cannot get these older people out of those homes. Is there something we should do? My bill does not address the abusers specifically, to be honest with you. Should we—can we create an environment for those who are abusers to be rehabilitated? Or should we give up on these people?

Ms. GALLOWAY. I would like to respond to that because, when I spoke about receiving 1,046 complaints of abuse, again, the older person does not want to put the child or the relative out of the home. They want the abuse to stop. So somehow we must develop programs that will meet the needs of the perpetrators. And, again, if the perpetrator is out of the home perhaps they might perpetrate against somebody else. So I think once the problem comes to our attention as an adult protective services agency, we must put in place or insure that the services are there to meet the needs of the victims as well as the perpetrators.

Ms. OAKAR. To your knowledge, is this a problem—is this an American problem? Elder abuse? Or is this an international problem? Who wants to answer?

Ms. TAYLOR. We have seen more and more research that indicates it is becoming more of an international problem. And it is the fact of the mobility of the family, the more demands being placed on the caregivers. As Barbara indicated, we need to look at the perpetrator, what is causing them to be abusive. Is it the stress? Is it the medical problems? Is it the mental health problems? Is it alcohol? Is it the fact that they are co-dependent on each other whether financially or for some other reason? Has some of this gone on before? What options can we present? And it is not just a problem in the United States. We are looking at it in other countries also. And as you mentioned, aging, people are older much longer. At the back of my testimony I provided some statistical data and just over the past 5 years, our number of reports are increasing with the 80-through 89-year-old group. So we are looking at a very old population that has limited resources and we have family members who also have limited resources. I think we talked about provision of services, respite care, and looking to see what options we can provide for those individuals.

Ms. HOUCHEN. I would support what they both have said. I think it is key to provide services for treatment for—not just the victim, but the abuser. And programs where you can provide supportive services for in-home care or respite care, I think those are key because many people are trying to do the best they can, but are stretched to their limit. And that in itself is a result of abusive and neglective situations. It is necessary that services be provided to support people in their homes, whether it is in-home care or in an adult care facility, such that there is some relief or some other people coming in to help and to teach families how to care for someone and when to get medical care help. I think that will have a positive impact on this whole issue.

Ms. OAKAR. Does anybody want to add anything?

Senator, did you?

Senator DRAKE. Yes, thank you, Representative Oakar. I am amazed. I worked all the summer before last on House Bill 317 which formed the Department of Alcohol and Drug Addiction services in the State where we do have a cabinet level director. We had some problems with that because people did not want to give the Governor a new cabinet level director. However, I worked all summer long, did not go out of town, but the one area I heard from mental health people, I heard from alcohol people, I heard from drug people and they were at my door. I mean I had to separate them in different rooms because at that point no one was agreeing on this bill. And I did have the three groups in my house one day because my secretary had mixed up on the scheduling and I thought I was going to have World War III. But anyway, we were able to bring all these factions and these people together and come out with I think a very good bill, but the one area that no one ever came to me on was the elderly alcoholic or addictive person throughout the entire summer. And as I sit here, that really amazes me because it is an area that should have been addressed.

We have a very good woman director, Lucille Fleming who many of you know is doing an outstanding job. And we did put 56 million new dollars in from the State and that has been matched with $56 million from Federal funds. So we have put a lot more money into this, but this would seem to me an area that we should be talking to Lucille about to see whether we could divert some of those funds in this direction and to help the situation. But I think that is where that would lie with that department. I truly do.

Ms. OAKAR. Well, we have some ideas on what the States are doing in this area and I would be happy to share them with you, and the people who work with the State. And maybe we can arrive at some better solutions.

Let me just close the hearing now and just to thank all of you on this panel. You are all distinctive women who really work very, very hard at what you do, probably undervalued and underpaid as well. We are delighted to have all of you.

I wanted to also thank Sandra Coyle who is the Program Administrator for the Gero Psychiatric Unit at Lutheran. I recall that the first site of geriatric mental health center, among the first in the country was the grant that Lutheran Hospital was able to get. And they promptly stole one of my staff people away from me, Carol Miller, Dutch Miller who now is doing other things, but she was on that team. And I think it is one of the best people groups around. Lily Hernandez of your Media Services Department, you just could not have been better in terms of helping us and the Administration for Lutheran Medical Center.

I also wanted to recognize Elizabeth Lowe who is a social worker here with Lutheran. She was one of our—is she here? She just left. Well, it is sometimes better to talk about people when they are not around if it is positive, but I wanted her to know how much I appreciated her work and I am glad to see she is here at Lutheran.

Years ago, when we were looking for studies, I remarked earlier that I could not find a study in the Library of Congress about elder abuse in 1978 and 1979. Ironically, I found one or became aware of one that was done in my home town which made me very proud. She and others who did document their work at the Chronic Illness Center were witnesses in 1980 and they are about the only ones who had had any kind of study or insight about this problem over a decade ago. And I am delighted that she is still working as a worker in this area and as a court liaison, legal advocate and resource for the patient, staff and the families. And Lutheran should be proud to have her on board.

I also want to thank Kathy Gardner who is the Staff Director of the Health Subcommittee which I am so honored to serve on. Kathy was a long-time staff person with Senator Claude Pepper. And when he died a year ago last May, we were lucky to have Kathy stay on with her institutional knowledge and her dedication to issues like this. Kathy who came in from Washington, knows how much I appreciate her work and I want to thank Scott Frey of my staff who is here from Washington who worked very hard on some of the aging issues that I am confronted with, including mammography coverage. So the men are interested in this subject, too, and we finally got some positive things. I know you are going to pass that State bill about mammography in the near future. I hope,

too, that we can mandate that these insurance companies have prevention in their coverage, which many of you mentioned today; preventive health care is neglected by and large. And I want to thank Jan Papez on my staff for all of her coordinating work and just did a great job. And I want to thank Mary Darrah of my staff, as well, who worked on this hearing for us and all of you who are present.

You sometimes wonder, as the Senator can tell you, whether or not these hearings do any good. I think they do. I really do, particularly when you can have them out in the field. The more the public is aware of this problem the more outraged they will be that we have not done what we should be doing on a national level and funnel it down. And while we have about $5 million more, and I hope the State gets its fair share since Ohio is one of the leading areas in elderly populations in the country, we have a lot more to do. The priorities of this country really rest with what the people want. So hopefully this will be educational as well.

Thank you all for attending. Thank you, Senator, for attending.

Ms. KAINE. I wish to give accolades to our Honorable Congresswoman Mary Rose Oakar who has worked tireless to help people of all areas. At the 1977 hearing in Cleveland, Ohio, chaired by Senator Glenn, Mary Rose Oakar was a participant and I testified then. I am still working in all of these areas and I want everyone to know it is important to become involved. She has worked tireless, but we must come out and support her and support others and get involved because this is important to our Nation.

I am now 78 years old, have been working in these areas for over 62 years. I have not given up. I have other areas which I must address and help others. There are other ways of sharing with people, but at this time I want you to know you must participate, you must be aware. It is important from the cradle to the grave to treasure and protect our people and to give them a quality life. Education is key at all levels. God bless you all.

Ms. OAKAR. Thank you very much for your kind words.

The hearing is adjourned.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

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