SB

122

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF ADMINISTRATION

OLDER ALASKANS COMMISSION

POUCH C, M.S. 0209
JUNEAU, ALASKA 99811
PHONE: (907) 465-3250

March 10, 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

During your recent hearing for SB 122 (Elder Abuse) testimony was given by Beth Bishop on the role of services in eliminating the root causes of elder abuse. The strain on families caring for an older member is frequently linked to abuse. Therefore, services which provide relief or assistance to families are seen as desirable. Respite care programs can be critical to this. Because you expressed interest in respite care I have taken the liberty of sending you the enclosed article.

Alaska and the other states in federal Region X are also working on a conference to be put on by the Northwest Long Term Care Gerontology Center (U. of W.) regarding respite care. If you should desire other information do not hesitate to contact the Commission.

Sincerely,

Jon B. Wolfe

Jon B. Wolfe
Executive Director

Enclosure

cc: Eleanor Andrews
Deputy Commissioner
Department of Administration

Rebecca Burch
Special Assistant
Department of Administration

Beth Bishop, Project Director
Southeast Senior Services

RESPITE CARE: AN EMERGING FAMILY SUPPORT SERVICE

By

Judith W. Meltzer

The Center for the Study of Social Policy
236 Massachusetts Avenue, N.E.
Suite 405
Washington, D.C. 20002

June, 1982

This work was supported by the Administration on Aging, U.S. Department of Health and Human Services under a Cooperative Agreement with the National Conference on Social Welfare.

Preface

This paper is one of a series developed by staff of the Center for the Study of Social Policy under a contract with the National Conference of Social Welfare. For the past 18 months, the National Conference has been supported by the Administration on Aging, U.S. Department of Health and Human Services to disseminate information on recent long-term care developments to state and local governments, professional societies, consumer and provider groups and others involved in the development of long-term care programs and services. As part of that effort, the Center for the Study of Social Policy worked closely with several State Departments of Aging, pursuing program issues which they identified as important to them. The paper which follows, on the development of respite care services as an important family support for community-based long-term care, is in response to specific requests for information from State Aging and Human Service agencies. In preparing this paper, the Center gathered materials from many states and is particularly grateful for their cooperation and willingness to share information. It is our hope that this paper and the others in the series will provide informational assistance for the many people in every state and local community who are currently engaged with the difficult issues of planning for, financing, organizing and providing community-based long-term care services for the elderly and disabled.

Introduction

One of the most pressing social planning tasks of the decade revolves around the need to develop coherent systems of long-term care services for the elderly and disabled. The growing numbers of people in every area of the country and at all income levels who need assistance in planning for, finding and paying for needed long-term care services has elevated the issue to a major domestic priority. In searching for solutions, policy analysts have belatedly recognized the importance of the family in the care-giving system and are only now beginning to appreciate and worry about the family caregivers--the stresses placed on them and the kinds of supports and incentives they need. This understanding has been translated into a policy emphasis at the federal and state levels on "preserving informal supports," a phrase that has come to encompass both financial and service strategies which make it easier for spouses and relatives to care for the elderly and the disabled in their own homes. The decision to pursue strategies which enhance and protect informal supports is an appropriate one for several reasons. First, it reflects the strong desires of most elderly and disabled to remain in their own homes or with relatives if at all possible. Second, research evidence suggests that, contrary to mythology about abandoning the elderly, most families want to care for their relatives and make decisions about institutionalizing the elderly and the disabled very reluctantly and only in the absence of any realistic alternatives. Thirdly, from a public policy perspective, it is clear that for most individuals the costs of home care with supportive services are considerably lower than institutional care. Given the large and growing numbers of persons at risk for long-term care assistance and the enormously high costs of institutional alternatives, it is imperative that options which enable and support family caregiving be developed.

The subject of this paper is respite care, a newly-defined service area in the constellation of long term care services which is primarily directed toward the family caregiver as opposed to the person in need of long-term care services . Respite means relief and, in its most general sense, respite care encompasses a wide range of services which offer relief to the spouse or relative who has assumed the responsibilities of caring for a dependent elderly or disabled person. P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981 includes respite care as one of the home and community-based long-term care services which may be provided under a Medicaid waiver. Several states are now in the process of developing respite care services as demonstration projects or as part of state long-term care service systems and many have requested information about what is known and is being done around the country with respect to respite care. The purpose of this paper is to assess the current state of knowledge about respite care and to offer some guidance to state and local governments and community organizations interested in developing respite care services. Part I briefly reviews statistical and research evidence which supports the need for respite care services. Part II reviews the varied definitions and models for both in-home and institutonal respite care which have been developed in several states and localities. Part III provides the results of the few existing evaluations of respite care, and Part IV concludes with recommendations for program development.

Part I - The Need for Respite Care

Respite care has only recently been recognized as a useful and needed supportive service for families caring for dependent elderly and other disabled adults. Since the 1960's, respite care services have primarily been developed and financed as part of efforts to deinstitutionalize developmentally disabled and mentally retarded children. Much of the impetus for respite care grew out of research on the effects on the family of having handicapped children live at home including parental stress, anxiety and isolation and the need to free parents' time and energy to care for non-disabled family members. Respite care services for the developmentally disabled have been sporadically made available through State Mental Retardation agencies and Developmental Disabilities Councils to provide short-term relief to family caregivers both in the family's own home and in licensed institutions and foster homes. The objectives and design of respite care programs for the disabled have varied but in general they have been developed to (1) encourage non-institutional care of disabled children, (2) provide emotional and practical support to family caregivers and (3) provide a basis for organized in-home interventions including habilitation services, family education and counseling.

The potential application of the concept of respite care to the elderly and the adult disabled is an emerging development reflective of a growing interest and understanding of the importance of family caregivers and informal supports.[1] An analysis of data on health and social factors relevant to long-term care policy by Butler and Newacheck shows that most elderly and disabled are institutionalized not because of a change in health status but because of a change in marital status and living arrangements, such as the death of a spouse or the inability of a child to continue to care for them.[2] Somewhere

between 60 and 85 percent of all disabled and impaired persons are helped in signficant ways by families,[3] a fact which is only now beginning to be appreciated by policymakers and planners. It is the elderly with few or limited family relationships who are the most vulnerable for institutionalization when they become ill.[4] Family caregiving is desirable, extensive but also precarious and fragile and too little attention has been paid to the stresses placed on the caregivers and meeting their needs.

The caregivers whom respite care services can help are primarily spouses, (mostly wives with disabled or elderly husbands) and children, (mostly daughters and daughter-in-laws), who care for their elderly parents or in-laws. According to 1979 census data, 75 percent of men aged 65 and over, 78 percent of men aged 65 to 74 and 67 percent of men aged 75 and over live with a spouse. Thirty-seven percent of women aged 65 and over, 47 percent aged 65-74 and 21 percent aged 75 and over live with a spouse. About 10 percent of men over 75 and 27 percent of women over 75 live with relatives other than their spouse. Recent research has focused on the needs of wives who care for elderly disabled men[5] and daughters who care for their parents.[6] Fengler and Goodrich in a study of women who cared for their disabled husbands highlighted their social isolation, loneliness and role overload.[7] Elaine Brody, in a study of three generations of families in Philadelphia, found that the amount of help given increased sharply as the age of the caregivers and their mothers increased.[8] Caregivers between ages 40 and 50 averaged three hours of help weekly; between 50 and 59, 15.6 hours weekly and those over 60 provided 22.7 hours of weekly help to their elderly mothers. Brody has called these caregivers "women in the middle" and described them as middle-aged women who experience the stresses of multiple roles and expectations as workers, spouses, filial caregivers, parents and even grandparents. Brody's research calls attention to the role and value conflicts faced by these women who want

to help their parents but are confronted with competing demands, pressures and desires to engage in out-of-home work. She found that the amount of help provided to relatives did not correlate strongly with the work/non-work status of the caregiver. Brody's research raises the important policy issues of how to prevent the stress of caregiving from becoming too great a responsibility and even a burden, although one which is usually willingly assumed by spouses and other family caregivers. Respite care, if available and accessible to the caregiver, is one of a constellation of family support services that many believe can help to alleviate such stress. The need for respite care services is in many ways an intuitive response to a perceived problem. There have been very few formal evaluations of respite care services for disabled children and almost none for the elderly and adult disabled. If family caregiving is to be encouraged, as most policy analysts, legislators and the public would urge, then ways must be found to support the family caregivers. Respite care, in a variety of forms, emerges as an important option. The remainder of the paper explores this further by describing existing and planned respite care programs and examining issues in the further development of respite care services.

Part II - Recent Developments in Respite Care

Available information on state respite care programs is at best fragmentary, reflecting both the emerging nature of respite care as a recognized long-term care service and the lack of any clear state financing and program development strategies. The description and discussion in this paper of state respite care programs and plans are not comprehensive but are representative of what is going on around the country, both in urban and rural states. The charts which follow provide information on state respite care programs in Connecticut, Delaware, Florida, Kansas, Kentucky, Louisiana, Maine, Missouri, Montana, New York, Oregon, Pennsylvania and Vermont. Some other states which have developed respite programs as part of demonstration efforts (i.e., California, South Carolina, Utah) or who are currently planning programs under Section 2176 Medicaid waivers have not been included.

The charts array information on state programs according to the following categories:

- Definition of respite care
- Eligibility
- Eligible Providers
- Financing
- State Administration
- Additional comments

Some general observations on each of the categories are provided below.

Definition of Respite Care

There is no uniform definition or model for respite care programs. In almost every state surveyed, respite care was defined differently although there were similar elements in many of the definitions. Respite care is most generally used to refer to temporary or short term relief of caregiving

responsibilities by someone caring for a dependent individual, usually a family member (a spouse or child) living with them. Respite care is used to refer to either in-home or out-of-home care, or both. In-home respite care can include sitter-type services or can be temporary use of homemaker chore and/or home health services. Out-of-home care includes both adult day care services, temporary stays in respite group homes or foster care homes or temporary stays in nursing homes, rehabilitation centers, hospitals or other health related facilities. For example, Connecticut law defines respite care as short-term temporary care of eligible persons on a planned or an emergency basis in the home of the eligible person or in a respite care center, whereas in Montana respite care only refers to temporary out-of-home care in licensed foster homes or private non-profit agencies. Many states further define respite care by specifying a maximum allowable use of care, either in number of hours or days of allowable care. For example, Florida's Home Care for the Elderly program limits respite care to 240 hours of respite service per year while Louisiana's limit is 1440 hours per year. The essence of the definition of respite care lies in its purpose which is almost uniformly to relieve caregivers from the constant stress and demands on their time. An additional purpose most clearly articulated in those states utilizing or hoping to use Medicaid funds to finance respite care, is the goal of reducing institutional care by providing incentives, services and supports for community-based living arrangements.

Eligibility

Eligibility for respite care services varies across states even more than the definitions. Several of the states surveyed limit eligibility to the mentally retarded/developmentally disabled population (i.e., Kentucky, Montana); others include the elderly, the developmentally disabled and the

mentaly ill (i.e., Connecticut, Vermont) and still others provide respite care only to the elderly at risk of institutionalization (i.e., Florida, Minnesota, Missouri, New York). Several states have included an assessment of functional limitations and of the need for community long-term care services as a part of the eligibility determination process. Often this is part of a preadmission screening process for nursing home admission. In Minnesota, for example, respite care services are authorized by county nursing home preadmisson screening teams which assess client needs and arrange for services as an alternative to institutional placement.

There is also variation on the imposition of an income test for receipt of publically financed respite care services. In general, the early programs financed with MR/DD funds and directed primarily at families with mentally retarded/developmentally disabled children had no income tests, although in some places, sliding fee scales were locally imposed. More recently created programs focused on the elderly and adult disabled populations are more likely to include an income limit. Kansas, for example, imposes the Medicaid income eligibility test of having an income of less than $310 per month. Kentucky and Missouri similarly tie eligibility to Medicaid standards but include provisions for a Medicaid spend-down.

Eligible Providers

Eligible respite care providers are as diverse as the programs themselves and depending on the nature of the specific program design include a wide range of formal health and social service providers as well as informal providers who are not the primary caregivers. Delaware, for example, purchases services from a variety of public and private non-profit providers and does not license respite care or home health providers. Few states license respite care providers directly although a statewide respite coalition in Ohio has supported a bill in the Ohio legislature which would license

respite providers and set standards for eligibility and the amount and method of payment. The question of eligible providers is related to the definition of respite care and the overlap between what is considered respite and what is day care, home health care and in some cases temporary nursing home care. In the New York Respite Care Demonstration project, respite may be provided by any service or combination of services supplied by individuals, social services districts, a public agency or a private not-for-profit corporation, a licensed residential health facility (SNF or ICF) or home health agency. There is no such thing as a single respite care provider and a variety of resources can be seen as potential respite services.

Financing

Inadequate, fragmented and inconsistent funding of respite care services appears to be the dominant pattern, similar to many other newly developing community long term care services. Until very recently, the funding sources available for respite care were extremely minimal. They include state and local appropriations, Title XX, Older Americans Act and Developmental Disability funds. Several states with Medicaid Section 1115 and federal long-term care experiments also included limited provision for respite care in their demonstration programs (i.e., Utah, South Carolina, California). The lack of permanent financing has been cited as a particular problem by several states examining the potential of respite care services. Recently, however, with the enactment of Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), many states have already or are in the process of requesting waivers of the Medicaid program which will enable them to expand their provision of in-home and community-based long term care services in order to prevent institutionalization. Respite care is one of the services included in the waiver and several of the states in our survey have made such

requests to the Health Care Financing Administration (i.e., Florida, Kansas, Kentucky, Montana, Minnesota, Missouri, Oregon and Vermont). One of the explicit hypotheses of the waiver experiments is that the provision of community long term care services, including respite care, can help reduce the costs of institutional long term care. Current research on respite care programs does not provide any evidence to either support or refute such a hypothesis.

State Administration

State administrative responsibility for respite care programs appears to be closely tied to the source of financing (i.e., Medicaid, Developmental Disabilities) and in turn to the population served (i.e., Elderly, Developmentally Disabled). In states where several funding streams exist (i.e., Delaware, Vermont) distinct programs are separately financed and administered, with little coordination or connection between seemingly related activities. One interesting feature of the administrative patterns of the states in our survey which are utilizing Medicaid funds for respite care is the linkage between preadmission screening for nursing homes, case management and respite care as part of a constellation of family support services. The coordination of respite care services with other family and in-home supports seems particularly appropriate and desirable and one which should be carefully assessed over the next several years.

For those states interested in developing a respite care program, our survey of what states are currently doing provides fruitful ideas but little in the way of evaluative data which can be used to structure a program. There is widespread agreement and interest in developing respite care services but very little research and practice knowledge to guide program development.

Because of this lack of data and information, two state legislatures, Connecticut and New York, enacted Respite Care Demonstration Projects last year. The New York demonstration was designed to encourage the initiation and expansion of respite and to evaluate the effectiveness of respite in deterring institutionalization. It is also hoped that it will provide information on the demand for respite, the most appropriate kinds of respite care services for different levels of disability and the costs of respite services. Five projects were funded out of 42 applications received by the State Department of Social Services. Four of the projects were to be focused on coordination, information and referral and systems development, and one on the efficacy of a slidiing scale fee schedule for those not Medicaid eligible but unable to meet the full costs of respite care. The need for this kind of information is obvious, as evaluative data is in short supply. The following section of the paper briefly reports on the few existing evaluations of respite care, a report of a small research program in California and a study of institutional respite care in six facilities in New York State.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Connecticut	Short-term temporary care of eligible persons by trained respite care providers. Can be on a planned or emergency basis in the home of the eligible person or in a respite care center. Includes in-home care and out of home care on an hourly basis not to exceed 24 hours or on a daily or weekly basis. Limit of 30 covered days of respite care in any calendar year. (Public Act No. 81-40)	Persons with severe chronic disability which is: 1. Attributable to a mental or physical impairment or combination, 2. Likely to continue indefinitely, 3. Results in functional limitations in two or more areas of major life activity, and 4. Reflects the need for a plan of care and interdisciplinary long-term care.	Not specified.	State appropriations for Respite Care Demonstration Project.	Department of Health Services, Community Nursing and Home ealth Division.	Demonstration project established by state in May 1981. A limited amount of respite care is also purchased with Development Disabilities funds or provided by Department of Mental Retardation funded agencies for the developmentally disabled.
Delaware	Provision of short-term care (several hours to several days) to provide relief to families caring for dependent individuals. (Definition adopted by community-based services task force of Delaware Long-Term Care System Development project.)	Not specified. Under consideration as part of long-term care systems development grant. Existing services provide respite primarily to handicapped and developmentally disabled although a few programs serve all age groups.	Public and private non-profit health and social service agencies.	Developmental Disabilities, Medicaid/Medicare (Home Health Services); Title III of the Older Americans Act through R.S.V.P.	Purchase of service arrangements through state agencies; no single administrative structure.	

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Florida	One of family preservation services provided under Home Care for the Elderly (HCE) project to encourage provision of care for elderly in family type living arrangements within private homes. Purpose is to provide opportunity for caregiver to have a rest away from the stresses and demands placed on them. Caregivers are eligible for 240 hours of respite care services per year. This can be increased to 360 hours when recommended by the case manager.	Persons 60 and older who meet Title XIX criteria for institutional care.	Community Care for the Elderly (CCE) authorized program service agencies. No specific licensing for respite agencies. Usual provider is a licensed home health agency. The CCE case manager authorizes respite care in the service plan. It is arranged for by the HCE adult services counselor.	State appropriation; Title XIX demonstration funds.	Department of Health and Rehabilitation Services through either local AAA's or district offices of HRS.	Florida has submitted a request to HCFA for a Section 2176 Title XIX waiver to provide respite care for the aging, disabled, and mentally retarded populations.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Kansas	Temporary short-term services provided in person's home or in an institutional setting. (A more precise definition of services and duration is being developed by the state.)	Medicaid eligibility (income of less than $310 per month, and in need of nursing home care services not available in the community). Respite care will be provided as one of a range of community services to prevent institutionalization.	Local health and social service providers.	Medicaid; cost of community based services (including respite care) must be 10% less than nursing home care in area.	State Social & Rehabilitation Services. SRS local caseworker and nurse from Home Health Agency (or contract R.N.) will assess client needs. This pre-admission team will develop a plan of care if the evaluation shows that the client could be prevented from nursing home entry if community care is provided and if such care is 10% less costly than nursing home care. The team submits plan to state SRS for approval. Services are then arranged through local case manager.	Kansas has submitted a request to HCFA for a section 2176 Medicaid waiver to finance this program. Expected implementation date is July, 1982.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Kentucky	Services provided to an individual on a short-term basis because the person who usually provides care is absent or needs respite. Limited to up to ten days per year.	Eligible person must be aged, disabled or mentally retarded and have care needs at the ICF/SNF level. They must have resided with the caretaker seeking respite for at least two months. Local home health agency must assess need and determine that no relative is available to provide respite without cost. Financial eligibility up to Medicaid spend down level.	Medicaid providers of homemaker/home health services. Family/client is responsible for locating respite care providers.	Title XIX (Reimbursement cannot exceed ICF daily rate).	State Division of Medical Assistance; Local Home Health Agencies (hospital based, local health departments, other) must do an assessment of eligibility and need for respite care and obtain pre-authorization from the Division of Medical Assistance.	Kentucky has submitted a waiver request to HCFA under Section 2176 to finance the described program.
Louisiana	Temporary in or out of home care provided for up to 30 days (720 hours) in a six-month period to a developmentally disabled or handicapped person.	Persons of all ages with a developmental disability or handicap. Persons whose handicap results primarily from old age are excluded, however 41% of those receiving in-home respite in FY 1981 were over 65.	In-home by a skilled caretaker associated with a respite placement agency. Out-of-home by a certified facility (i.e., community respite center residential treatment facilities, pediatric hospitals, nursing homes, ICF's, day care centers, etc.).	100% state funds. (Prior to 1979-1980, Title XX funds were used.)	State Department of Health and Human Services.	Primarily focussed on MR and DD populations.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Maine	(Respite care is not now	covered under any entitlement program or other	sources of funding.	Possible use of Title XX	funds in the future.)	
Minnesota	Respite care services are provided through the Alternative Care Program when required as an alternative to nursing home placement. Respite can be provided for an individual who is unable to care for him/herself and needs short term care due to caregiver absence or need for relief. Services can be in an individual's home or in a facility approved by the state, including a hospital, nursing home, foster care home or community residential facility. Respite care service can include room and board as a reimbursable item in per diem rate.	Persons aged 65 or older (Those who are Medicaid eligible are supported by Medicaid funds; all others are supported by state grants to counties.)	Not specified.	Medicaid; state appropriation ($1.8 million FY '81) (As of 1981-82, state provides grants to counties which have adopted voluntary nursing home pre-admission screening program. 25 of 87 counties now participate and more are expected to after July 1.)	State Department of Public Welfare (Pre-admission Screening and Alternative Care Program) administers grants to counties with operational PAS programs. When a client applies to nursing home a team of M.D., public health nurse and social worker perform screen and determine service needs. Counties set up their own procedures for respite care.	Minnesota has submitted a waiver request to HCFA under Section 2176. Prior to the enactment of State Alternative Care Program, about six counties used county funds to provide respite care.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Missouri	Includes two-day stay in nursing facilities; extended stay not to exceed six weeks if primary caregiver is hospitalized and needs to be away from constant care; also in-home respite on a daily basis for client who is homebound or in case of emergency.	Medicaid eligible persons over 60, in need of ICF level care. Medicaid spend down allowed.	Not specified.	Medicaid, Older Americans Act, Title XX.	The Division on Aging, Department of Social Services. Respite is part of community service package to be provided under channeling demonstration in Kansas City and pre-screening case management program being instituted in two counties. Initial assessment will be by M.D.'s fol'owed by pre-admission screen by DSS social workers when person applies to nursing home or through hospital discharge. Social worker (state employee) or private agency worker in channelling site will arrange for service.	Missouri has submitted a request to HCFA for a Section 2176 Medicaid waiver to finance respite care and other needed community services.
Montana	Out-of-home care for no more than six months during any one twelve-month period.	Families with children who are developmentally disabled and between the ages of 0 and 6 without regard to income. Physician's evaluation of severity, cause and age of onset of disability required.	Care is purchased from licensed foster homes or private non-profit agencies who have contracts with the State Developmental Disabilities Division. Purchase is authorized by county social worker or developmental disabilities specialist	State appropriation; Title XX	Developmental Disabilities Division, Department of Social and Rehabilitation Services.	Montana has submitted a request to HCFA for a Section 2176 Title XIX waiver to provide respite care for the mentally retarded population.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
New York (Nursing Home Without Walls)	Assessing the need for, arranging for and providing the temporary institutional and home care services needed to allow family members who ordinarily care for the patient relief from these duties when such services are included in a plan of care as approved by a physician.	Persons assessed to be in need of ICF or SNF care for whom home care can be provided at average annual expense of no more than 75% of cost of institutional care. No age restrictions. Private pay patients eligible at either Medicare or Medicaid rate.	Certified home health agency, hospital or residential health care facility (SNF or ICF).	Medicaid (Section 1115 Waiver).	State Departments of Health and Social Services.	Demonstration program operating in 13 urban and rural localities in the state.
New York (Respite Care Demonstration, Project Chapter 767 of Law of 1981	Provision of infrequent and temporary substitute care or supervision of frail or disabled to provide relief from the stresses or responsibilities of providing constant care. Respite shall be limited to periods of 24 consecutive hours or longer, but may not exceed six weeks in any calendar year for any individual.	Caregivers of frail or disabled adults. Priority to those frail or disabled adults 60 years or older. Caregivers are defined as the family member or other natural person who normally provides daily care or supervision. Caregiver may, but need not reside in the same household as frail or disabled adult.	Respite may be provided by any service or combination of services supplied by individuals, social services districts, a public agency or a private not-for-profit corporation or any licensed residential health facility (SNF or ICF) or home health agency.	State appropriation of $430,000 for demonstration. ($60,000 for state administration and $370,000 to fund 5 demonstrations. Direct service costs to be secured if possible from Medicaid, Medicare, third party payers and clients.)	Department of Social Services.	Demonstration project to encourage the initiation and expansion of respite, evaluate the effectiveness of respite in deterring institutionalization, evaluate demand for respite and ascertain the most appropriate service for various levels of disability and disfunction and for the cost of the services and their coordination. Five projects will be funded. Four projects are for coordination, information and referral and systems development. One is an improved fiscal access project which will provide respite on a sliding fee scale for those not eligible for Medicaid, but unable to pay full costs.

STATE RESPITE CARE PROGRAMS

STATE	DEFINITION OF RESPITE CARE	ELIGIBILITY	ELIGIBLE PROVIDERS	FINANCING	STATE ADMINISTRATION	ADDITIONAL COMMENTS
Oregon	(Not currently provided by State or as part of FIG Waiver Long-Term Care Demonstration Project. Request has been submitted to HCFA for a Title XIX Medicaid waiver under Section 2176 to provide respite care for the mentally retarded.)					
Pennsylvania	(During 1979, Title IX funds from the Older Americans Act were used to train and employ older State Domiciliary Care home providers. Due to budget cuts, this program was discontinued.)				workers to serve as respite workers for the	
Vermont	Respite care services are short-term interventions provided to persons who are unable to care for themselves in the absence of those who normally provide such care. Services may be provided in an individual's home or a facility approved by the state for respite. The extent and schedule of care is determined by family or other caretaker need. May include a number of hours per week (limited respite) or for longer periods to enable a family to vacation.	Elderly; Developmentally Disabled State-funded Program for the MR/DD population available without regard to income. (Medicaid waiver request for MR/mentally ill population will add Medicaid income requirements and need for ICF level of care, but ineligible families will still be eligible for state funded program.)	1. Home health agencies. 2. Agencies serving the developmentally disabled.	1. State general fund appropriation ($700,000 FY 1981) for home care services to purchase "limited respite care." 2. State general fund appropriation for family support services, including respite care, for MR clients. 3. ACTION provides stipends for senior companions to provide elderly respite care.	1. Department of Health. 2. Department of Mental Health/Division of Community Mental Retardation Programs. 3. Through local AAAs.	Vermont has applied to HCFA for a Section 2176 Title XIX waiver to provide respite care to the MR/mentally ill population.

Part III - Existing Research Regarding Respite Care

The basic premise behind state and local interest in developing respite care services is that it is an important social support to family caregiving and that the presence of such social supports plays a critical role in influencing who goes into a long-term care institution and who remains in the community. Respite care services, whether in-home assistance or temporary institutional care which enables a break in the daily routine of caregiving is believed to relieve the physical and psychological pressures associated with caring for the chronically ill elderly and disabled. As mentioned earlier, the basic intellectual impetus for respite care has been drawn from research on families caring for retarded and developmentally disabled children. The parallels to the elderly and adult disabled population have only recently begun to be explored.

In Marin County, California, a small program that began as a peer support group for older women caring for their disabled husbands at home, evolved, at the suggestion of the wives, into a respite care project which included case coordination, adult day care, home care and extended respite care.[9] In the Wives' Respite Project that developed, the term respite care was used generically to refer to any services that provided intervals of rest and relief for the principal caregiver. Funded with $40,000 for a two-year period, the program provided home care, overnight/weekend respite at a community residential facility and community/professional education. Home care was provided by one full-time nurse who divided her time between 10-15 persons requesting service averaging about four hours per week per couple. It is interesting to note that the participants preferred the dependability of one respite care worker to whom they could relate over time rather different workers each time they requested hep. The in-home respite care worker performed the following functions: companionship, supervision, health,

teaching, household tasks, shopping, meal preparation, emotional support and personal care. The overnight respite program used a small facility which was licensed as a six-bed adult group residential facility and linked to an adult day care center program, thus minimizing adjustment by the husbands and wives to strange people surroundings. The wives used the weekend care to go away or simply to stay at home without the pressure and responsibility of daily personal care chores for their disabled spouse. The conclusion drawn by the researchers involved with this project was that, for a relatively small investment, the project provided an enormously important resource for the involved families.

The only larger scale evaluation of a respite care program that our literature search and state survey revealed was an eighteen month project in New York state which was financed with foundation funds to demonstrate and assess the impact of providing institutional respite care as a support service for families caring for the frail elderly.[10] The project supported the development of respite care programs at six long term care facilities in New York state and examined the hypotheses that (1) respite care fills an unmet need for long-term care for the elderly in New York state; (2) respite care relieves the pressures that families feel in the care of frail elderly; (3) respite care is seen as a positive experience by the participants; and (4) providers are willing and able to provide institutional respite care services.

The facilities participating in the demonstration were licensed New York state health related facilities providing ongoing SNF and ICF care. Each facility agreed to reserve several beds for respite care patients. During the life of the project, the average age of the respite care patient was 81.6 (similar to the average nursing home resident) and the average length of stay was 18 days. Seventy-two percent of the caregivers used the respite service

for vacation and relief purposes. The sources of the payment for the respite care service were Medicaid (20 percent), Medicare (3 percent), Patient (66 percent) and caregiver (10 percent). The vast majority of the respite patients required SNF level of care and the evaluators concluded that institutional respite as a relief program has the greatest impact on SNF placements.

The findings of the evaluation report regarding regulatory, financial and other policies are summarized here because they represent a systematic assessment of some key issues that need to be considered when developing respite care programs. With respect to regulatory policies, the evaluation found that in a highly regulated environment like New York state, institutional respite care services could be developed with a moderate amount of regulatory conflict and that modification of some regulations could provide strong incentives to providers to offer respite. Specifically, they recommend that institutional respite care services not be established as a distinct program, thereby requiring a full and separate Certificate of Need review. Instead, they should be informally established as part of existing SNF and ICF facilities. In addition, since New York state, as is the case with many other states, requires detailed patient assessments and utilization reviews for persons entering a nursing home, provision should be made to waive these requirements for respite care clients. With respect to financial policies, the study found that the additional costs associated with providing respite were not a major barrier to facility participation. The projected annual cost of participating in the program was $18,000-$25,000 per year per facility or $5,000-$12,000 per bed attributable to the costs associated with vacant beds produced by short-term stays and additional personnel costs of short-term entry and discharge. The vacant bed costs arose because respite occupancy was lower (60-80 percent) than SNF-ICF occupacy (98-99.5 percent). The financial

pressures and system characteristics which propel facilities to maintain high occupancy rates is the major factor inhibiting the further development of respite in health facilities. The evaluation recommends trying to develop a Title XIX reimbursement methodology for respite which would clearly identify those costs unique to admission and treatment of a person for a short time as well as exploring the possibilities of other third party insurance for respite care and the development of a sliding fee scale for those above Medicaid eligibility. It is interesting to note, however, that the project found a strong demand for respite care among private paying patients willing and able to pay the prevailing rates which ranged from $30 to $90 per day.

Finally, four other findings were significant. First, the study found an unexpectedly helpful positive role played by nursing respite providers as a referral agency, informing and educating families of other support systems for home care. Second, the temporary admission to a nursing facility afforded a positive opportunity for reviewing and changing drug regimens for many patients. Third, there was a positive correlation between a higher level of need and a higher demand for respite. The most important time for respite services appears to be when the older person requires the most care. Fourth, and perhaps related to the above finding, was an unexpectedly high rate of institutionalization (12 percent) of the respite care population within one month of use of respite services. This compares with a rate of about .4 percent per month for a comparable 75+ population. This is an important finding with two possible explanations, each with significant policy implications. Either of two things may be occurring. The use of institutional respite services may represent one last attempt by a family to keep their relative out of an institution, suggesting that without the respite service the institutionalization rate for this population may in fact have

been higher. The other explanation is that a positive experience with institutional respite may break down family barriers to institutional placement, making it easier to permanently institutionalize the client. Clearly this issue requires greater study in the near future, particularly if policymakers are looking to respite care as a service which helps prevent institutionalization.

Part IV - The Future of Respite Care Services

As the analysis in this paper has shown, there is considerable state and local interest and activity regarding the development and implementation of respite care services but not a lot of evaluative knowledge about the extent of need, the costs of providing respite care, the best ways of organizing, financing and providing access to care, and the impact of offering respite care as a support for family caregiving. It is a service area which suggests an intuitively correct approach to assisting those who take on the responsibilities of caring for the elderly and the disabled and, as such, is an important component of state efforts to promote and assist family caregiving. In concluding, three issues which have not yet been directly addressed must be emphasized. First, respite care should not be viewed as a separate service program but should be considered as part of a system of family support functions linked to case management systems or other local coordinating mechanisms. Case managers can assume a critical role in assessing needs for care, providing access to respite care providers and matching the individual needs of the client with the personality, skills and services of a particular provider. Second, consideration should be given to extending eligibility for respite care services beyond state Medicaid eligibility levels, perhaps with sliding fee scales adjusted for income. Existing evidence suggests that families are willing to pay for the service and those who can should be required to do so. Financial support for those who cannot may offer a desirable positive incentive for family caregiving. Thirdly, attention must be paid to the issue of training respite care workers so that they are sensitive to the needs and demands of the families they serve. Care should be taken to avoid over professionalizing and bureaucratizing what is essentially an informal support, while at the same time devoting necessary resources to the training of respite caregivers.

The recent interest by the Federal government, states and localities in assisting those who take on the responsibilities of caring for elderly and disabled relatives and friends is encouraging. The challenge of meeting the long-term care needs of current and future generations of elderly and disabled will require new creativity in the financing and provision of respite care and other community and family support services.

FOOTNOTES

1. For a full discussion of the research on informal supports in long-term care, see Steinitz, Lucy, "Informal Supports in Long-Term Care: Implications and Policy Options, "Center for the Study of Social Policy, February, 1981.

2. Butler, Lewis and Newacheck, Paul, "Health and Social Factors Relevant to Long-Term Care Policy," in Policy Options in Long Term Care by Meltzer, Farrow and Richman, eds. (University of Chicago Press, 1981).

3. Callahan, James J., Diamond, Lawrence, Giele, Janet Z. and Morris, Robert, "Responsibility of Families for their Disabled Elders," University Health Policy Consortium, July, 1979.

4. Shanas, Ethel, "The Family as a Social Support System in Old Age," The Gerontologist, Volume 19, No. 2, 1979.

5. Fengler, Alfred P. and Goodrich, Nancy, "Wives of Elderly Disabled Men: The Hidden Patients," The Gerontologist, Vol, 19, No. 2, 1979.

6. Brody, E., "Women's Changing Roles and Care of the Aging Family," Aging Agenda for the 80's, National Journal Issues Book, 1981.

7. Fengler & Goodrich, Ibid.

8. Brody, E.. "Women in the Middle and Family Help to Older People," Gerontologist, Volume 21, No. 5, 1981.

9. Fengler & Goodrich, Ibid.

10. Respite Care for the Frail Elderly: Final Report, February, 1982, Foundation for Long Term Care, Albany, New York.

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: SB 122 Date on Bill: 2/11/83
Title: "An Act relating to protection of the elderly"
Sponsor: Senator Josephson and Fischer
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

(Thousands of Dollars)

			FY 83	FY 84	FY 85	FY 86		
Capital								
Operating								
Total			-0-	-0-	-0-			

b. Revenues:

Revenue								

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor.

Prepared By: Jon B. Wolfe, Executive Director Phone: 465-3250
Division: Older Alaskans Commission Date: 2/24/83

Approved by Commissioner: Date: 3/1/83
Department: Admin.

5. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor
Copy to Requestor

2/8/83

Statement of Support for SB 122 - Mandatory Reporting of Elderly Abuse.

Thank you for allowing my statements to be read as part of this hearing. I am unable to travel to Juneau today. I would have appreciated the opportunity to speak myself by teleconference, but do understand the problems in scheduling this hearing as a statewide teleconference.

I am very pleased that Senator Josephson and Representative Clocksin have introduced SB 122 and HB 192, a companion bill. I strongly support the mandatory reporting of suspected or known elderly abuse by health care professionals. Ten years of active duty hospital nursing and four years of emloyment in community service programs for the elderly have, in my opinion, given me some insight into elderly abuse.

The older people of this country are like other dependent populations in society. They as individuals understand and live by the old moral - "don't bite the hand of the one who feeds you". It has been recognized nationwide that child abuse was the issue of the 60's, spouse abuse of the 70's and now elderly abuse of the 80's. If SB 122 passes, Alaska joins other states in recognizing the need to report Elderly Abuse.

I was a member of the Anchorage Elderly Abuse Task Force, which began to discuss and study this growing problem well over a year ago. Although a study of the incidence of Elderly Abuse was done in Anchorage by Community Mental Health Annex, until mandatory reporting of Elderly Abuse cases is a law, we have no total picture of the problem.

Mandatory reporting will insure that health care professionals will report Mrs. X cuts and bruises and broken bones, even when Mrs. X is the mother of a neighbor. This support and legal backup will enable the reporter to make a moral decision and follow through on it without fear.

I encourage the passage of this bill as a positive step in assuring that all residents of Alaska can live in comfort that "victimization" is not our way of life in Alaska. Who, more than our Pioneers and Elders, deserve this comfort?

Norma Lundy
Anchorage

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: SB 122 Date on Bill: 2-11-83
Title: An Act relating to protection for the elderly
Sponsor: Josephson
Requestor:

1. Estimated fiscal impacts on:

a. Expenditures:

(Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86
Capital				
Operating				
Total	-0-	-0-	-0-	-0-

b. Revenues:

Revenue	

2. Source of funds to offset fiscal impact of bill:

3. Assumptions:

No Fiscal Impact

4. Disclaimer:
This statement has not been reviewed by the OMB in the Office of the Governor. It therefore does not represent the final estimate of fiscal impact.

Prepared By: Francis C. Allan Phone: 269-5691
Division: Alaska State Troopers Date: 2-16-83

Approved by Commissioner: [signature] Date: 2/25/83
Department: Public Safety

5. Distribution:
Original to Legislative Finance
Copy to OMB
Copy to Sponsor
Copy to Requestor

2/15/83

To: Representative Walt Furnace

From: Steven C. Levi, Staff

RE: SB 122

Date: February 23, 1983

SB 122 is a bill for the protection of the elderly. Staff feels the bill deals with a subject of merit but wishes to express concern as to four sections of the bill.

1) Staff notes that in AS 47.24.010 (a)(9) the clergy is listed as a responsible party who must, within 24 hours, report an abuse to an elderly citizen. Staff notes that this may infringe on the separation of Church and State. [Page 2, Line 8]

Staff notes that in dealing with the elderly Sec. 47.24.010 (f), a person is required to report a suspected incidence of violence and such person "is immune from prosecution." Yet, this seems to imply that if a persons commits the act and then, in good faith, reports it, there is no case for criminal prosecution. [Page 3, Lines 4-8.]

Staff notes, AS 47.24.030 (a) that if the Department of Health and Social Services deems that protective services are needed and it cannot receive consent from the elderly person, the Department may petition to court for the "appointment of a guardian or temporary guardian for the elderly person for the purpose of obtaining consent." Staff wonders if this would lead to court cases where the elderly person felt that his or her rights were being violated by having a guardian forced upon them. [Page 4, Lines 1-6.]

Staff notes, AS 47.24.075, that "neither the physician-patient nor the husband-wife privilege is a ground for excluding evidence regarding an elderly person's harm, or its cause, in a judicial proceeding." Staff expresses concern that such a policy may be unreasonable or unusual.

Staff suggests discussions with Rose Palmquist and Sam Pestinger.

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF PUBLIC SAFETY

POUCH N
ROOM 312, GOLDSTEIN BUILDING
JUNEAU, ALASKA 99811
PHONE:

COUNCIL ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

April 12, 1983

Number of victims 55 years of age and older reported through Alaska Council on Domestic Violence and Sexual Assault state forms:

	Domestic Violence
1982	
July	4
August	5
September	4
October	5
November	3
December	3
1983	
January	1
February	3
Total	28

Karen VanDusseldorp.

Karen VanDusseldorp
Research Analyst

12-L16LH

FACT SHEET ON ELDER ABUSE — Based on Aging Committee Report, April, 1981

Incidence of Elder Abuse

4% of older Americans are victims of some sort of abuse each year — this is equal to one million older persons per year

The "typical" abused older person is a 75 year old woman who relys on others for her care and is repeatedly abused by the caregiver

The "typical" abuser is a caregiver who is experiencing a great deal of stress, often from marital or financial problems, and may resort to alcohol or drugs to relieve his stress.

21% of the abusers are the sons of the older person
17% " " " " " daughters " " "
the 3rd most likely abuser is the spouse (husband more often than wife)

Older persons do not report abuse because they are ashamed, frightened of retaliation, or do not want to cause family troubles

More than 70% of reported cases are reported by third parties

Case histories were presented from all States in the following categories: physical & sexual abuse, negligence, financial exploitation, psychological abuse, violation of personal rights & self neglect

1/3 of the cases were incidences of physical abuse
1/4 " " " " " " financial exploitation

STRESS is believed to be a major factor leading to the abuse of older persons by caregivers — one study found that the elderly person was a significant source of stress in 63% of the cases

Other factors leading to abuse may be: retaliation, violence as a way of life, lack of financial resources & community supports, resentment of dependency, increased life expectancy, and over-crowded living environment

State Responses to Questionnaire

63% of the States said the greatest hinderance to their ability to help the abused elderly was lack of appropriate statutory authority — the second most frequest hinderance was lack of skilled staff, community resources, and funding (MRO's BILL IS AIMED AT RESOLVING THESE PROBLEMS

On a national average, only 6.6% of state funds for protective services are spent on services for abused elderly (Ohio spends less than 1%)

Only 16 states require mandatory reporting of elder abuse:
Ala., Ark., Conn., Fla., Kent., Minn., Missouri, Neb., New Hamp., N. Carol., Okla., S. Carol., Tenn., Utah, Vermont & Virginia

An additional 10 states have legislation pending (including Ohio)

When asked if states would favor passage of H.R. 769, 74% answered YES, the remaining 26% answered UNDECIDED

Elder Abuse in Anchorage, Alaska October, 1981

FINDINGS OF A.C.M.H.C. - 1981 - Alaska

In the study conducted by A.C.M.H.C. of 75 cases documented, 34 cases (43.3%) of physical abuse were found. A breakdown of the abuse sustained follows:

lack of personal care	17.3% *
bruises and welts	13.3%
lack of food	10.7%
medicines withheld	8.0%
freezing	6.7%
malnutrition	6.7%
direct beatings	5.3%
abrasions and lacerations	2.6%
bone fractures	2.6%
sexual assault	1.3%
imprisonment	1.3%

Psychological abuse was sustained by 53 elders (70%)

fear	46.7% *
verbal assault	28.7%
threat	18.7%

Material abuse occurred in 43 cases (57.3%)

misuse of money or property	45.3% *
theft of money or property	26.7%

* categories are not mutually exclusive

There was violation of rights in 18 cases (24%)

forced social isolation	16.0% *
forced from home	6.7%
forced into nursing home	5.3%

STATISTICS ON VICTIM

Age of abused elder at the time of the abuse

60 - 70	41.3%
70 - 80	41.3%
80 - 90	13.3%
90 +	4.0%

Sex of Victim

Female	76.0%
Male	22.7%
Couple	1.3%

Race or Ethnic Group

White	69.3%
Native	18.7%
Black	9.3%
Hispanic	1.3%
Unknown	1.3%

STAISTICS ON VICTIM (continued)

Economic Status of Victim

Low	54.7%
Middle	29.3%
High	12.0%
Unknown	4.0%

Degree of Physical or Mental Impairment

Physically or mentally disabled to a great degree	38.7%
Need some assistance with Activities of Daily Living (ADL's)	21.3%
Physically self-sufficient	40.0%

Resides at the same address as victim

Alone	17.3%
Family member(s)	41.3%
Husband/wife	14.7%
Girl/boyfriend	8.0%
Boarding home	4.0%
Nursing home	4.0%
Housekeeper	5.3%
Friend(s)	4.0%
Unknown	1.3%

STATISTICS ON ABUSER

Relationship to victim

Daughter	22.7%
Son	21.3%
Husband	10.7%
Grandaughter	1.3%
Grandson	1.3%
Girlfriend	4.0%
Boyfriend	1.3%
Son-in-law	1.3%
Daughter-in-law	9.3%
Hired caretaker/housekeeper	6.7%
Entire family	5.3%
Boarding home	4.0%
Friend	10.7%

Age of abuser

20's	6.7%
30's	22.7%
40's	36.0%
50's	12.0%
60's	14.7%
70's	2.7%
80's	1.3%
Unknown	4.0%

STATISTICS ON ABUSER (continued)

Ethnic Group of Abuser

White	65.3%
Native	20.0%
Black	8.0%
Hispanic	1/3%
Unknown	5.3%

Economic Status of Abuser

Low	44.0%
Middle	22.7%
High	16.0%
Unknown	17.3%

Does the Abuser Live With the Victim?

Yes	69.0%
No	22.7%
Unknown	1.3%

OTHER INFORMATION

Is alcohol a factor in this situation?

Yes	49.3%
No	41.3%
Unknown	9.3%

Has this mistreatment happened before?

No	2.7%
Once	9.3%
2 - 3 times	8.0%
4 or more	74.7%
Unknown	5.3%

How did you know about it?

Self report	49.3%
Private M.D.	5.3%
Hospital	22.7%
Police	0
Public Social Service Agency	5.3%
Private Social Service Agency	6.7%
Public Health	2.7%
Neighbor	1.3%
Professionals Observation	6.7%

Did the victim seek help?

Yes	53.3%
No	43.7%
Unknown	4.0%

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT

Elder Abuse in Anchorage, Alaska

A Survey of Service Providers

Teri B. Spires B.S.
Charles R. Mundorff M.S.

October, 1981

Project of Anchorage Community Mental Health Center Geriatric Unit

Annex 1020 East 4th Avenue 99501 (907) 276-5400

ELDER ABUSE IN ANCHORAGE, ALASKA

ELDER ABUSE IN ANCHORAGE, ALASKA

Teri Spires, B.S. and Charles Mundorff, M.S.

Anchorage Community Mental Health Center, Anchorage, Alaska

This study was done in response to the phenomenon of elder abuse in the State of Alaska. This particular study, focused in the Anchorage area, was designed to assist in establishing perameters to the problem. Thirty agencies, 16 physicians, and four medical clinics were contacted. Seventy-five cases of elder abuse were documented. There were 34 cases of physical abuse, 53 cases of psychological abuse, 43 cases of material abuse and 18 cases of violation of rights.

Introduction

Abuse of the elderly by their spouse, family or caretaker is a problem often observed by service providers in the Anchorage area. Elder abuse in the past has not been addressed as a specific issue in Anchorage until the last year. Previous to this study, no research had been done in Alaska, but nationally a few studies have been conducted. These studies provide a good data base that exposes the incidence of elder abuse and the need for concern in our society. Unfortunately, elder abuse has not been addressed in Alaskan domestic violence programs. Consequently, the Region X Office on Aging targeted Anchorage as a pilot city for study and community planning in elder abuse.

In November 1980 a meeting of representatives from Alaska, Idaho, Washington and Oregon was called by Chisato Kawabori (Ph.D.), Director of Region X Aging Network, and Willard Mollerstrom (Ph.D.), Region X Director of N.I.M.H. Charles Mundorff of Anchorage Community Mental Health Center (A.C.M.H.C.) attended this meeting in Seattle. At this meeting, A.C.M.H.C. was considered a focal point for the problem of elder abuse in the State of Alaska.

At this time, A.C.M.H.C. was given the opportunity to receive a VISTA (Volunteer in Service to America) to research the problem and make recommendations for mental health programming for abused elders. The following study is a result of the VISTA's effort. These findings are compared to national results in order to lend a clear picture to service providers. This procedure will help determine any differences between Alaska and other states.

National Findings

Three major elder abuse studies have been done since 1979. They are from Boston, The University of Maryland and the University of Michigan. The latter were partially funded by the federal government. In June of 1979 there was a briefing by the House of Representatives Select Committee on Aging entitled Elder Abuse: The Hidden Problem. This briefing was held in Boston, Massachusetts. On April 28, 1980, a briefing on the same subject, domestic abuse of the elderly, was held in Union, New Jersey. The early research findings of these efforts are remarkably consistent, despite great differences in research approaches and settings.

The major studies of elder abuse point out the tentativeness of their results. Yet, the completed studies provide an excellent approach to the problem, and a profile of the victim and the abuser emerges.

The Massachusetts study, Block's Battered Elder Syndrome, and the Lau-Kosberg study points out the victim tends to be an older elderly person. The Massachusetts survey finds 55% of the citings are persons older than 75 years. All three studies agree that abuse is observed to be of elderly women (87% in Lau-Kosberg, 80% in Massachusetts, and 81% in The Battered Elder Syndrome. The majority of victims live with an adult child or other family members who become the abuser.

Usually the victims suffer from one or more disabilities which place them in a vulnerable position. Of the Massachusetts study respondents, 75% said the victim had physical or mental disabilities which kept him or her from meeting basic daily needs. Marilyn Block finds 62% of the victims could not prepare food, 54% could not self-medicate, and 62% needed help with personal hygiene. Besides physical impairment Lau and Kosberg report 41% are either partially or totally confused or senile. It is easy to imagine from the research that a victim of abuse is usually a person who may need constant attention and skilled care. These two factors can and do cause stress for the caretaker, who is at risk of becoming an abuser.

The Massachusetts survey finds in 75% of the abuse cases, the abuser lives with the victim; 86% of the abusers are relatives of the victim. The Battered Elder Syndrome finds close correlation: 81% of the abusers are related to the victim. Block also finds women, more often than men, are abusers. The figure cited is 58% of abusers are female. The Massachusetts study finds sons (24%), husbands (20%), and daughters (15%), make up the largest categories of abusive relatives. Lau and Kosberg find 30% of abusers are daughters, 14% are sons, 14% are grand-daughters, 12% are spouses, and 12% are siblings (usually a sister).

The Massachusets study finds the abuser is usually experiencing stress when the abuse occurs. The study finds 28% suffer from alcoholism or drug addiction, 18% complain of long-term medical problems, 16% struggle with long-term financial stress and 9% suffered from lack of needed services. The Battered Elder Syndrome points to psychological (58%) and economic (31%) factors leading to abuse. The Massachusetts survey finds 63% of respondents feel that the vulnerable elder,

requiring a high level of emotional and financial support, is a source of stress. In 58% of cases studied, abusers tend to repeat the abuse, according to Block.

One of the most remarkable statistics to come out of these studies has to do with the attempt to make cases of abuse known. Block finds in 95% of the cases studied, some attempt was made to communicate the existence of neglect or abuse to some authority. This fact points to the poor communication skills of the abuser and to the low self-esteem he or she may feel. After a failed attempt to get needed services, the abuser may give up. After a failed attempt to get help, the victim may, out of fear of reprisal, or removal from the home, resolve to live with the situation. This fact also points out the failure of social services systems to recognize cries for help from both the victim and the abuser.

Methods and Designs

From March 1, 1980 to June 30, 1981, A.C.M.H.C. conducted a survey of service providers concerning elder abuse. Thirty agencies, four clinics and 16 physicians were contacted.

Those who said they had seen cases were further contacted. They were asked to relate cases they had seen from January 1, 1980 to June 30, 1981. They were asked to give the first name and last initial of each person in every case. This was done to prevent duplication of information from agency to agency.

The cases were recorded on the form used by Marilyn Block and Janice Davidson in their study, The Battered Edler Syndrome. All questions were asked for each case (see Appendix A). One additional question was asked of each respondent concerning every case: is alcohol a problem in the situation?

The definition of elder abuse used in this study is the one used by Marilyn Block and Janice Davidson in their study.

Abuse refers to one or more of the following acts:

> physical abuse, including direct beatings, lack of food, lack of medical care, and lack of supervision;
>
> psychological abuse, including verbal assault, threat, fear, and isolation;
>
> material abuse, including theft or misuse of money or property and;
>
> violation of rights, including forced removal from home, or forced entry into a nursing home.

We are concerned with people who are 60 years or older. These are people who are in some way dependent on a son, daughter, other relatives or caretaker.

There is a high degree of interviewer reliability since only one person conducts the interviews. Agency contacts, mailings and interviews were all done by the same person.

The data obtained from the survey is summed and the percentages calculated. Thus the data is descriptive in nature and not intended to be baseline data. It must be stressed that the figures obtained from the agency contacts are estimates of what the professional feels are abusive situations. Estimated are based on second-hand knowledge so these results cannot be generalized beyond the agencies cooperating.

Results

Two major groups were contacted for this study. First, 30 agencies who showed an interest in senior citizens or are service providers were initially interviewed in order to assess which agencies had seen cases

they were willing to relate. The following is the contact list and some preliminary information about each (see below).

Agency Contacted	a.	b.	c.
1. Salvation Army	11	yes	yes
2. Nakoyia	2	yes	yes
3. Adult and Aging Services	5	yes	yes
4. Mable T. Caverly	3	yes	yes
5. Studio Club	2	no	yes
6. Municipality Senior Programs	1	yes	yes
7. Providence Hospital	6	yes	yes
8. Older Persons Action Group	5	yes	yes
9. Legal Services	2	yes	no
10. Home Health Agency	5	yes	yes
11. Chugiak Senior Citizens Center	2	yes	yes
12. Senior Companion/Foster Grandparent	1	yea	yes
13. Alaska Hospital	2	yes	yes
14. S.T.A.R. Standing Together Against Rape	2	yes	yes
15. R.S.V.P. Retired Senior Volunteer Program	1	yes	yes
16. C.I.N.A.. Cook Inlet Native Association	2	yes	yes
17. Anchorage Police Department	1	yes	1*
18. Catholic Social Services	1	yes	yes
19. A.W.A.I.C. Abused Women's Aid in Crisis	3	yes	yes
20. Women's Resource Center	1	yes	no
21. Public Health Nurses	11	yes	yes
22. State Senior Citizen Ombudsman	1	yes	yes
23. Easter Seals Homemakers	2	yes	yes
24. Alaska Native Hospital	7	yes	yes
25. A.C.M.H.C.	6	yes	yes
26. Equal Rights Commission	1	yes	no
27. Palmer Pioneer Home	1	yes	yes
28. Palmer Senior Nutrition Site	2	yes	yes
29. University Justice Center	1	yes	no
30. AK. Public Interest Research Group	2	yes	no

Key to Headings:

a. Number of persons contacted.
b. Does agency feel that elder abuse is a problem in Anchorage at this time?
c. Has agency seen any abuse cases since January, 1980?

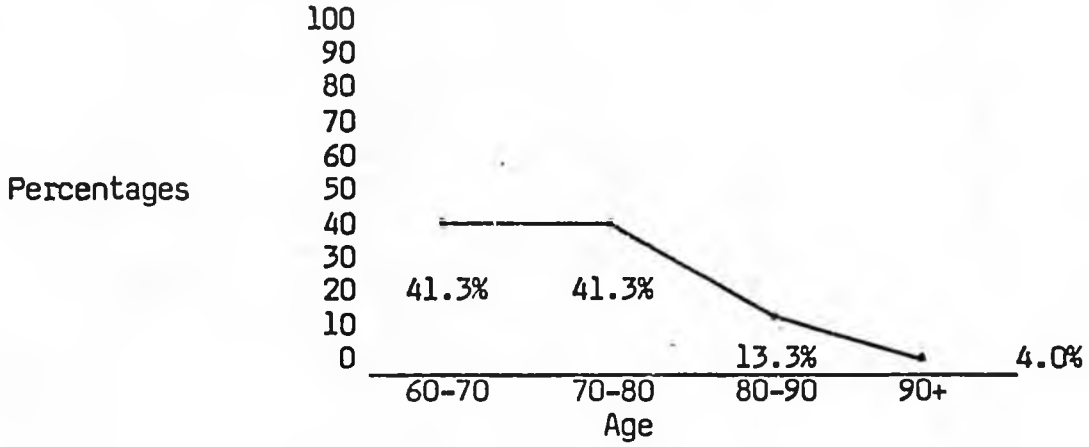
*1. No record-keeping methods.

The second group contacted were physicians and clinics. A letter (see Appendix B) was sent to 16 physicians and four medical clinics. The names of 12 of the physicians were given to A.C.M.H.C. by the Municipal Senior Citizens Division. These physicians treat many older people or have expressed an interest in aging patients. The letter asked the physician or clinic to relate any cases of elder abuse they may have seen. Of the twenty contacted, none responded.

Twenty agencies related elder abuse cases. Seventy-five in all were related to the interviewer. This breaks down to an average of 3.75 cases per agency. The most cases in one agency was eight, the least was one. Of the 75 cases reported, 34 or 43.3% had some element of physical abuse. The most common physical abuse is not violent in nature. Lack of personal care constitutes 17.3%, bruises and welts 13.3% and lack of food 10.7%. The remaining percentage in all categories are found in Appendix C. Psychological abuse is found in 53 cases or 70%. Material abuse occurs in 43 cases or 57.3%. There is violation of rights in 18 cases or 24%.

The age of the abused elder in the Anchorage area is younger than in the Lower 48. Unlike the national studies, the exact ages of the victims can not be determined. Most professionals know only the general range of their client's age. Of the 75 cases, 82.6% were under 80 years. This statistic is not surprising considering the general youth of the Anchorage population. The abuser in our area is also younger than in other urban areas. The abuser is under 50 years old in 65.4% of the cases related to the interviewer.

Figure I. Percentage of Abused by Age



The abused elder is most likely to be female. In 76% of the cases the victim is a woman. This percentage is comparable to the national statistics. Also similar to the national statistic is the sex of the abuser. In Anchorage 53.4% of the abusers are women. In Marilyn Block's study 58% of the abusers are women. Daughters are first on the list at 22.7%, sons second at 21.3%, husbands are third at 10.7% and daughters-in-law are fourth at 9.3%.

The abused elder is most often observed to be White (69.3%). The statistic for the Native population is 18.7%; the Black population figure is 9.3%; and the Hispanic figure is 1.3%. Because the elder in most cases lives with a spouse or family member (55%), the statistic concerning the ethnic group of the abuser is almost exactly the same as the victim.

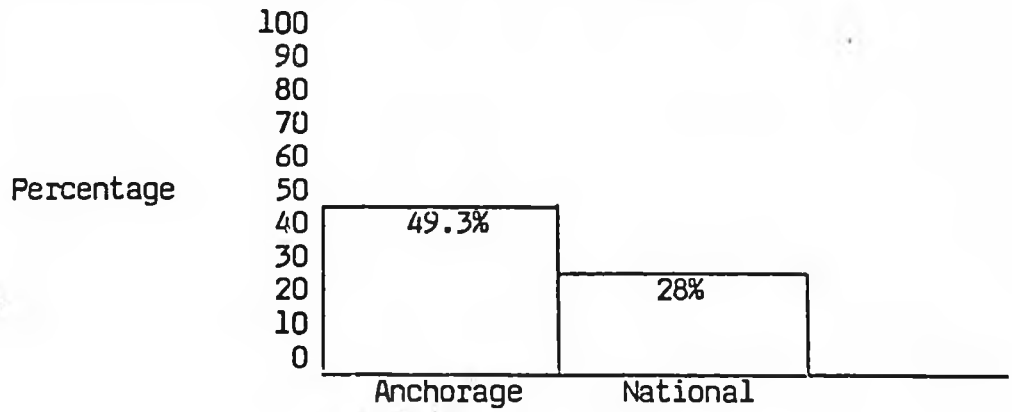
In most cases given to us, both the victim and abuser are low-income. Of the 75 cases, 54% of the victims and 44% of the abusers fit this category.

A question concerning the impairment of the victim was asked of all respondents. In 38.7% of the cases the abused elder is physically or mentally disabled to a great degree. In 21.3% of the cases the person

needed assistance with the Activities of Daily Living. In 40% of the cases the victim is physically self-sufficient.

Alcohol as a contributing factor in elder abuse seems to be a much greater problem in Anchorage than other areas. The national statistic is 28%, and in Anchorage it is 49.3%.

Figure II. Percentage of Alcohol as a Contributing Factor



In most of the cases observed (74.7%) the abuse had been going on for a long time. In some cases the abuse continued for years. In 53% of the cases the victim did seek help. But, just as significantly, 41.3% of the cases had not asked for assistance. The agencies responding found out about the abuse in any number of ways. The most common way was from the client (49.3%). Other reporting sources were hospitals or clinics (27.2%), private physicians (5.3%) and public or private social service agencies (12%). The agencies, when contacted by a reporting source, in most cases, responded to the victim with the services that the agency provides. In some cases the agency referred the clients to other agencies that could respond to other areas of need. Case studies are an excellent way to better understand how cases were being handled at the time of the survey.

Abuse Report Form

M. W.

First Name Last

I. Information on Victim

A. Age at time of incident 82

Sex M

Race or ethnic group caucasion

Religion unknown

Economic status high

Who resides at the same address girlfriend

B. Physical Abuse Sustained

X none	___bone fracture
___bruises, welts	___direct beating
___sprains dislocations	___lack of personal care
___malnutrition	___lack of food
___freezing	___medicine withheld
___burns, scalding	___no medicine purchased when prescribed
___abrasions, lacerations	___no false teeth when needed
___wounds, cuts, punctures	___no hearing aid when needed
___internal injuries	___no glasses when needed
___dismemberment	

Comments

C. Psychological Abuse Sustained

X verbal assault

X threat

X fear

D. Material Abuse Sustained

___theft of money or property

X misuse of money or property

X other trying to get him to sell his property

E. Violation of Rights

___forced from home
___forced into nursing home
___forced social isolation
___other_____

F. Rating of Environment

__X__dirt in house
___vermin in house
___inadequate heat
___smell of urine
___no food in house
___other_____
___none

G. Degree of Physical Impairment

___bedridden
___cannot perform basic personal hygeine without help, bathing, toilet
___cannot prepare own food
___cannot take own medicine
__X__none

II. Information on Abuser

A. Relationship to victim girlfriend
Age at time of incident 62
Sex
Religion unknown
Race or ethnic group caucasion
Economic status low
Occupation on disability
Does the abuser live with the victim? Yes X No___

B. What led to this mistreatment as far as you know?
She wants his money

1. Is alcohol a problem in this situation? no

C. Has this mistreatment happened before?

____no ____4 or more times

____once

__X__2 or 3 times

III. Reporting of Incident

A. How did you know about the case?

____self report

____private medical M.D.

____hospital or clinic

____police

____public social service agency

____private social service agency (nursing home)

____public health

__X__other by ongoing therapy

B. Did the victim ever attempt to seek help? no

What help?

C. Action taken (what did you do for this case?)

Provide mental health services

D. Additional comments:

Abuse Report Form

__ I. Unknown
First Name Last

I. Information on Victim

A. Age at time of incident 65
Sex F
Race or ethnic group caucasion
Religion
Economic status low-income
Who resides at the same address husband

B. Physical Abuse Sustained

____none
__X bruises, welts
____sprains dislocations
____malnutrition
____freezing
____burns, scalding
____abrasions, lacerations
____wounds, cuts, punctures
____internal injuries
____dismemberment
____bone fracture
____direct beating
____lack of personal care
____lack of food
____medicine withheld
____no medicine purchased when prescribed
____no false teeth when needed
____no hearing aid when needed
____no glasses when needed

Comments

C. Psychological Abuse Sustained

__X verbal assault
____threat
__X fear

D. Material Abuse Sustained

____theft of money or property
____misuse of money or property
____other

E. Violation of Rights

____forced from home

____forced into nursing home

____forced social isolation

____other_____

F. Rating of Environment

____dirt in house

____vermin in house

____inadequate heat

____smell of urine

____no food in house

____other_____

G. Degree of Physical Impairment

____bedridden

____cannot perform basic personal hygeine without help, bathing, toilet

____cannot prepare own food

____cannot take own medicine

_X_ none

II. Information on Abuser

A. Relationship to victim husband

Age at time of incident 62

Sex

Religion unknown

Race or ethnic group native

Economic status middle

Occupation laborer

Does the abuser live with the victim? Yes X No____

B. What led to this mistreatment as far as you know?

Gets angry when drinking, fighting.

1. Is alcohol a problem in this situation? yes

C. Has this mistreatment happened before?

___no

___once

___2 or 3 times

__X__ 4 or more times

III. Reporting of Incident

A. How did you know about the case?

__X__self report

___private medical M.D.

___hospital or clinic

___police

___public social service agency

___private social service agency (nursing home)

___public health

___other_____

_____

B. Did the victim ever attempt to seek help? yes

What help? Admission to Pioneer Home.

C. Action taken (what did you do for this case?)

Helping her to get a divorce and assist with Pioneer Home admission.

D. Additional comments:

Conclusions and Recommendations

From the study done by A.C.M.H.C. several conclusions and recommendations can be made. Most results are similar to the national statistics, but there are some differences.

The abused elder in the Anchorage area is most likely to be a White, low-income woman over 70. She lives with an adult child or family member. A person in Anchorage is more likely to be physically independent than the national counterpart. The abuser is apt to be a middle aged White, low-income woman. In a sense, she is a victim of her situation. In many cases she is experiencing stress due to crowded living conditions, inadequate income, health problems, ignorance about services and feeling as if she is parenting a parent.

These stresses can result in many kinds of abuse. Physical mistreatment is clearly acknowledged as abuse. The results of physical abuse are more obvious and often deemed more serious than the results of other types of abuse. Psychological abuse may be less obvious but it is no less damaging to the elderly person. Cases of psychological abuse were sited far more frequently than other types. All 20 agencies reported cases involving some form of psychological abuse. Of the 75 cases of elder abuse, 70% involved this abuse.

The dependence of elderly people on others leaves their financial affairs open to misuse and theft. Because some elderly feel as if they are a burden or they may be left alone, they do not always move to remedy a case of economic abuse. In Alaska, the existence of the longevity bonus, native claims settlement payments and a high incidence of alcohol abuse make elders prime candidates for financial exploitation by caretakers.

Alcohol as a contributing factor to elder abuse is much greater than in other areas of the United States. Alcohol abuse is not limited to the

abuser. In some cases the elder abuse victim misuses alcohol and in other situations it is family-wide. A.C.M.H.C. as well as other service providers feel that this possibility should be considered when providing services to abused elders and caretakers.

Agencies surveyed believe that there are some things that can be done that would help them deal more effectively with the problem of elder abuse. A list of these actions follows:

1. An elder abuse mandatory reporting law.
2. Improving low-income housing opportunities for the elderly.
3. Beginning an adult day care center in the Anchorage area.
4. Some provisions for in-home respite care.
5. More staff for protective services.

There was one major problem in doing a study of this nature in Alaska. The group studies is age 60 and older. The older native population has a gap in that age group because many of that generation died during the tuberculosis epidemic. There is a lack of information concerning elder native Alaskans because of this factor.

Though some conclusions about abusers and victims can be made, these people come from any race, social or income group. The elder abuse cases given to the A.C.M.H.C. are only a few of the cases that enter the social service system. The real numbers are still to be discovered. Through a pilot project, A.C.M.H.C. is launching a concentrated program of public education. We hope to encourage a public awareness that will foster voluntary reporting by service providers and the general public. We are far from solving the problems of elder abuse, but by using some of the same methods used by child abuse researchers in the 1960's we hope to gain a better understanding of and form a methodology for dealing with the serious social problem of elder abuse.

REFERENCES

Block, Marilyn R., and Sinnott, Jan D., eds. The Battered Eldered Syndrome; and Exploratory Study. College Park, Md.: The University of Maryland, 1979.

Douglass, Richard L., Hickey, Tom, and Noel, Catherine. "A Study of the Maltreatment of the Elderly and Other Vulnerable Adults." Ann Arbor, Mi.: University of Michigan, 1979.

Holden, David F., and Carey, Peggy L., eds. "Tennessee Conference on Abuse of Older Persons." Knoxville, Tennessee: University of Tennessee, 1980.

APPENDIX A

ELDER ABUSE REPORTING FORM

Abuse Report Form

_____

First Name Last

I. Information on Victim

A. Age at time of incident_____

Sex_____

Race or ethnic group_____

Religion_____

Economic status_____

Who resides at the same address_____

_____

B. Physical Abuse Sustained

____none
____bruises, welts
____sprains dislocations
____malnutrition
____freezing
____burns, scalding
____abrasions, lacerations
____wounds, cuts, punctures
____internal injuries
____dismemberment
____bone fracture
____direct beating
____lack of personal care
____lack of food
____medicine withheld
____no medicine purchased when presented
____no false teeth when needed
____no hearing aid when needed
____no glasses when needed

Comments_____

C. Psychological Abuse Sustained

____verbal assault
____threat
____fear

D. Material Abuse Sustained

____theft of money or property
____misuse of money or property
____other_____

E. Violation of Rights

____forced from home

____forced into nursing home

____forced social isolation

____other_____

F. Rating of Environment

____dirt in house

____vermin in house

____inadequate heat

____smell of urine

____no food in house

____other_____

G. Degree of Physical Impairment

____bedridden

____cannot perform basic personal hygeine without help, bathing, toilet

____cannot prepare own food

____cannot take own medicine

____none

II. Information on Abuser

A. Relationship to victim_____

Age at time of incident_____

Sex_____

Religion_____

Race or ethnic group_____

Economic status_____

Occupation_____

Does the abuser live with the victim? Yes____ No____

B. What led to this mistreatment as far as you know?

_____

_____

_____

1. Is alcohol a problem in this situation?_____

C. Has this mistreatment happened before?

____no
____once
____2 or 3 times
____4 or more times

III. Reporting of Incident

A. How did you know about the case?

____self report
____private medical M.D.
____hospital or clinic
____police
____public social service agency
____private social service agency (nursing home)
____public health
____other_____

_____

B. Did the victim ever attempt to seek help?_____
What help?_____

C. Action taken (what did you do for this case?)

D. Additional comments:

APPENDIX B

LETTER TO PHYSICIANS AND CLINICS

Dear Doctor:

During the last few months Anchorage Community Mental Health Center has been researching the problem of elder abuse in the Anchorage area. We are very interested in any experience you may have had with your patients or their families. The information is purely for research purposes. Names are not necessary and all reports are confidential.

We are using the definition used by Marilyn R. Block and Janice L. Davidson in their study The Battered Elder Syndrome.

Abuse refers to one or more of the following acts:

physical abuse, including direct beatings, lack of food, lack of medical care, and lack of supervision;

psychological abuse, including verbal assault, threat, fear and isolation;

material abuse, including theft or misuse of money or property and

violation of rights, including forced removal from home, or forced entry into a nursing home.

When you are searching your mind for cases that you believe may qualify as elder abuse, keep in mind that the age we are referring to is 60 or older. These are people who are in some way dependent on a son, daughter, or other relative or caretaker.

Any response or comment by you is considered essential to this study. Please call me by August 21, 1981 at A.C.M.H.C. 276-5400.

Teri Spires
Research Specialist

3944 Spenard Road, Anchorage, Alaska 99503 (907) 243-5411

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

AN ANALYSIS OF LAWS CONCERNING ELDER ABUSE: LRSE SUMMARY
(Alaskan statutory provisions substituted)

The following is a summary of the above referenced publication which was prepared by Legal Research and Services for the Elderly of Boston. Alaskan statutory provisions have been substituted to assist the reader to understand what legal remedies are available in Alaska.

The problem of elder abuse requires social service and legal remedies. In LRSE's view, the response models of child and spouse abuse are limited because they "have not necessarily been effective and because the elderly raise distinct issues."

The abuse elderly person is typically in a vulnerable and dependent position. The primary caretaker is often also the abuser.

I. TWO CLIENT GROUPS

a. Those who are willing and eager to pursue on their own initiative, service provisions or a legal (criminal or civil) remedy;

b. those who cannot or do not seek assistance and who enter the system through intervention procedures

   1. some form of State intervention may be an alternative

   2. the primary consideration is the individual's capacity to make the needed decisions.

II. RESPONSES

a. "Responses must make available and provide accessible, effective social services, alternative housing, health care, emotional support, etc. The parameters of these options must be expanded beyond what is currently available."

b. "Legislation, drafted to include a means for providing social and health services to the abused, must set forth the framework for procedures which can establish surrogate authority in cases where the abused elderly person lacks the capacity to consent to services or manage his/her own life and property. Concurrent with these procedures there must be protection of the due process rights of the elderly individual."

III. CRIMINAL REMEDY

a. Filing of criminal complaint, e.g., assault, blackmail.

b. If pursued, it should be in conjunction with a civil remedy or inclusion of protective orders during the criminal proceeding.

c. Linkage with service provision is necessary.

IV. CIVIL REMEDY

a. Under AS 9.55.600, "a person subjected to domestic violence may petition a superior court for injunctive relief restraining the infliction of further domestic violence against the petitioner by the respondent." (Domestic violence means a crime under AS 11.41.100 - 11.41.530 committed against a spouse, former spouse, or a member of the social unit comprised of those living together in the same dwelling as the respondent.) The order may include provisions which:

1. restrain the respondent from subjecting the petitioner to domestic violence;

2. direct the respondent to vacate the home of the petitioner;

3. restrain the respondent from communicating directly or indirectly with the petitioner;

4. direct the respondent to pay medical expenses incurred by the petitioner as a result of the domestic violence.

The court must send a copy of the order to the appropriate local law enforcement agency. Peace officers shall use every reasonable means to enforce an order.

AS 9.55.610 provides for emergency injunctive relief.

b. According to LRSE the degree of protection provided under such statutes depends on enforcement provisions. "...if protective orders are violated, the abused individual must return to court for further remedy. This not only makes the process more cumbersome, but also fails to address the need for immediate and effective protection and enforcement by the police. Particularly (sic) cases of elderly abuse, reliance on this procedure would significantly increase the difficulty on the part of any infirm individual to rely on the remedy of the law."

V. ISSUES RE LEGAL REMEDIES

"Often the elderly person will not agree to go to seek a legal remedy. Even if the individual is willing and eager to go to court, removing the caretaker from the home will require the social service system be able and willing to compensate for the lost support and assistance. Furthermore, shelters, which have been established to provide alternative housing for abuse victims often cannot meet the needs of the infirm or more dependent elder."

VI. PROTECTIVE SERVICES

The "social service agency must seek and obtain the consent of the individual before making a referral, discussing a case inter-agency, or instituting a case plan" in order to ensure the individual's right to privacy. LRSE also points out that this right which is fundamental to our legal system cannot be rationalized by the notion of the "best interests" of the client.

a. Non-judicial alternatives for elderly persons who need assistance but who do not lack capacity:

1. managing finances or access to resources

a. joint bank accounts, restricted bank accounts, direct deposit

b. representative payee for Social Security

2. Power of Attorney

3. Trusts

b. Judicial Alternatives

There are three judicial alternatives in Alaska: conservatorship, guardianship and civil commitment

1. Conservatorship

A. AS 13.26.165 states that a conservator may be appointed in relation to the estate and affairs of a person if the court determines that:

i. the person is unable to manage his property and affairs effectively for reasons such as mental illness, mental deficiency, advanced age, chronic use of drugs, chronic intoxications, confinement, detention by a foreign power, or disappearance; and

ii. the person has property which will be wasted or dissipated unless proper management is provided, or that funds are needed for the support, care and welfare of the person or those entitled to be supported by him and that protection is necessary or desirable to obtain or provide funds

B. This may be an appropriate course of action in a case of exploitation if the elderly person lacks the capacity to manage his property.

2. Guardianship

A. Under AS 13.26 a guardian may be appointed for an "incapacitated person," i.e., "a person whose ability to receive and evaluate information or to communicate decisions is impaired for reasons other than minority to the extent that he lacks the ability to provide for himself the essential requirements for his physical health or safety without court-ordered assistance."

B. AS 13.26.090 states:

Guardianship for an incapacitated person shall be used only as is necessary to promote and protect the well-being of the person, shall be designed to encourage the development of

maximum self-reliance and independence of the person, and shall be ordered only to the extent necessitated by the person's actual mental and physical limitations. An incapacitated person for whom a guardian has been appointed is not presumed to be incompetent and retains all legal and civil rights except those which have been expressly limited by court order or have been specifically granted to the guardian by the court.

C. LRSE points out that this is a "drastic remedy" and "rarely constitutes the needed and least restrictive option which is required by the large class of persons in need of protective services. Agencies often look to a guardianship as a means of getting decisions made that the elderly person refuses to make. Thus, it becomes a tool to enforce the service agencies' notions of (supposedly) the 'best interests' of the client."

3. Civil Commitment

AS 47.30.655 - 47.30.915 outlines the procedure for involuntary commitment procedures for a person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to himself or others.

VII. STATE INTERVENTION AND PROTECTIVE LEGISLATION

"Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals" conducted by LRSE indicated "that in a majority of the reported cases of abuse the elderly client is unable or unwilling to pursue a legal remedy on his/her own behalf. The survey results indicate that in a large proportion of cases a barrier to service provisions existed. The greatest percentage reported that this barrier was the refusal of the victim to acknowledge the problem or take action about it."

"The abuse, exploitation, neglect and abandonment of persons sixty and older often affects individuals who are infirm, confused and dependent. These persons may lack the physical ability or mental capacity to seek services or to consent to assistance. In such cases, remedies which require the initiation of the client are insufficient."

The issues of how and when to intervene in elder abuse cases in such cases poses a dilemma.

"Thus, is raised the classic conflict between the right of the individual to privacy and self-determination in opposition to the power of the state to intervene where state interests of protection of vulnerable persons exist.

Basic to our legal system is the individuals' right of self-determination and right to privacy. This constitutional right is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The individual's civil rights are not absolute or without limit. The state can and does intervene by regulation and prohibiting certain behavior. Intervention by the state results from a balancing of the state's interests against the interests of the individual to be left alone. The

parameters of state intervention are often unclear, reflecting historical and social trends,

Theoretically, state intervention occurs pursuant to two legal concepts:

a. the police power gives the state authority to regulate activities that involve the health and safety of society;

b. parens patriae gives the state authority to act in a parental capacity for persons who cannot care for themselves or who are dangerous to themselves.

While the state's exercise of its police powers has theoretically always been limited by the strictest of procedural safeguards in order to protect the individual from deprivation of his/her constitutional rights, the exercise of the parens patriae power has traditionally been marked by an atmosphere of informality. These informal procedures have been justified by the impression that the court's determination was to be based solely on the individual's 'best interest,' thus, eliminating the need for an adversarial process. This reasoning, although still adhered to, conflicts with reality in that the exercise of parens patriae often includes serious limitations on individual rights in the form of involuntary placement or institutionalization. Although clearly an infringement of the individual's rights, this rationale continues to enable the state to act in the supposed 'best interests' of the individual, often with minimal due process safeguards."

"The issues raised by this legislation are controversial, as well as complicated. Any discussion involves complex questions of a legal, medical and psychological nature. To these questions one brings the need for the intricate and delicate balance between the principle that society has the duty to protect those unable to protect or provide for themselves, and the constitutionally assured right of personal choice and individual freedoms.

The critical provisions of an abuse reporting and protective services law are those which determine and define how this conflict, between individual rights and state intervention, is resolved. These provisions primarily center around the definition of persons covered by the law, the standards for reporting and investigation as they affect rights of privacy and confidentiality, the right of access into private homes to investigate and to provide services, and due process safeguards in the determination and provision of involuntary services. In addition, there is the critical issue whether such laws are linked with service provision systems capable of meeting the needs of persons under the purview of the law. Further, the payment procedures for these services causes administration and legal difficulties.

Persons Covered

The premise of the protective services legislation is that persons exist in society who are unable to care for and/or protect themselves. Society, in the form of the State, as parens patriae, assumes the responsibility of this care and protection. The criteria for State intervention should clearly be one linked to the existence of abuse, neglect, exploitation and/or abandonment and a functional, mental or physical, inability to care for or protect oneself. The scope of the law and the determination of need on the part of persons covered should be defined according to this premise to

assure that vulnerable persons who are abuse victims are protected and reached by services."

VIII. LRSE STATUTORY RECOMMENDATIONS

The following are the LRSE recommendations for a protective services and abuse reporting statute:

1. The law should apply to persons sixty and over who are abused, neglected, exploited or abandoned, and to persons 18 and older who lack the physical or mental capacity to care for their basic needs and/or protect themselves.

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

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

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

   Abandonment refers to the desertion or willful foresaking of an elderly or incapacitated person by a caretaker and obligations owed an elderly or incapacitated person by a caretaker or other person.

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

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

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

   Anyone of the above categories who has reasonable cause to believe or suspect that an elderly or incapacitated person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such treatment shall make a report to the appropriate agency withing 24 hours.

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

6. The identity of the reporting person should be confidential and be disclosed only with the consent of that person or by judicial process.

A person acting in good faith who makes a report should be immune from civil and criminal liability.

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

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

   The agency chosen to receive and investigate reports should have a system and personnel to:

   A. receive reports 7 days a week, 24 hours a day;

   B. keep records;

   C. have knowledge of services available;

   D. have access to services;

   E. have a statewide mandate;

   F. have the ability and staff (trained) to respond quickly.

   A centralized intake system should be geared into a regional response system if possible.

   The investigating agency should also either provide services or coordinate service provision by subcontracting and referral. This should be determined according to existing State service systems.

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

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

    A. If the report is not verified, the case is closed.

    B. If the report is verified, an assessment of the individual's functional capacity, the situation and the resources available to the person should be made by a multi-disciplinary team with expertise in the particular field of disability.

11. In conducting the investigation, the agency may seek the assistance of law enforcement officials and the courts. If access is denied to the investigator, either by the elderly or incapacitated person or a caretaker, the agency may petition for a court order to enjoin intervention with access to investigate. Such an order shall be issued upon specific facts shown that: 1) there is a reasonable cause

to suspect that the person in question is or has been abused, neglected, exploited or abandoned; and 2) access has been denied to the representatives of the agency required to investigate such reports.

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

13. Voluntary services shall be provided for the least restrictive alternative, client self-determination, and continuity of care.

    A fair hearing procedure should be developed and implemented so that any service plan can be appealed on denial of application for specific services or for failure to provide the least restrictive alternative.

14. The department/agency should establish by regulation a sliding fee scale to be used in determining fees for services provided on a voluntary basis.

    The department should maximize all available Federal reimbursements for such services. There should be no charge to the individual in question for the cost of the investigation, assessment, etc. These costs are to be borne by the State.

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

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

    A. Assessment of need and eligibility

       adult refuses services
       lacks capacity to consent
       no one else can/willing to consent (See #22)

    B. Clear and convincing evidence

    C. Least restrictive alternative; non-institutional placement where possible

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

    E. Placement shall not be made in a mental institution, nor will any proceeding be a determination of incompetency.

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

    The adult in question shall be assured the right to counsel; if she/he is indigent, the court shall appoint counsel. The adult shall also

have the right to be present and to cross-examine the parties involved. If counsel is waived, the court shall appoint a guardian ad litem to act in the interest of the adult in question.

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

19. The court order for any protective placement must be specific as to such placement, including reasons for finding it necessary and that it is the least restrictive alternative. This should be stated in the court record.

20. The initial care plan submitted to the court should specify details of services, medical treatment, and relocation. The court order issued should be specific as to services, treatment, placement approved.

    Any modification can only be made pursuant to court order.

21. The court should limit the order to six months or less; upon court review, it can be extended for another period of time (up to six months).

22. The determination of 'lacks the capacity to consent' should be made according to the following:

    > the adult bases decisions on delusions or hallucinations, is unable to make or implement decisions, or is unable to comprehend a decision's effect. The decision itself for refusing services cannot be the sole evidence for finding the person lacks capacity to consent.

23. Involuntary services should be borne by the State unless a court, after a determination of financial ability, orders the client to pay or the client agrees to pay.

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

    Emergency means that an elderly or incapacitated person is living in conditions which present a substantial risk of death or immediate and serious physical harm to him/herself or others:
    a finding based on clear an convincing evidence that the adult in question is incapacitated and in need of services,
    an emergency exists,
    the individual lacks the capacity to consent, no one else can/is willing to consent,
    the proposed order is substantially supported by the findings.

In issuing an emergency order, the court shall adhere to the following limitations:

A. The court should specifically order those services necessary to remove the conditions creating the emergency.

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

C. Emergency intervention should be limited to a period of 72 hours, renewable for 72 hours upon a showing to court of necessity to remove emergency conditions.

D. Court should appoint a temporary guardian with responsibility for the person's welfare and authority to give consent for emergency services (as ordered by the court) for the duration of the order.

E. Court should provide that the elderly person is assured all rights except those limitations provided for in the order.

F. Access to the premises will be ordered by the court to carry out the order in cases where voluntary access has been denied.

26. Notice shall be provided (including relevant and factual information of the basis of the petition) to the person, his/her spouse, children, next of kin, or guardian at least 24 hours prior to the hearing.

This notice may be waived upon a showing that: 1) immediate and reasonable forseeable physical harm will result from the delay; and 2) reasonable attempts have been made to give notice to the above parties.

27. Emergency placement: If it appears probable from the personal observation of a police officer that an elderly person will suffer immediate and irreparable physical injury or death if medical care is not provided, and that person is incapable of giving consent, and that it is not possible to follow the hearing procedures, that office should be able to transport the person to an appropriate medical facility for medical treatment.

Notice of this action shall be given to persons listed in #26 within four hours. A petition for emergency medical intervention should be required to be filed within 24 hours of this action and a hearing should be held with all due process guarantees with 48 hours of the transfer.

28. In all cases, the drafting and adoption of adult protective service provisions should be linked with the developing of extensive service systems which emphasize alternatives to institutional care."

Missouri Gerontology Institute

Guide on AGING

Protective Services Legislation for the Elderly

C. Edwin Vaughan
Department of Sociology
and Center on Aging Studies
University of Missouri-Columbia

- *An 89-year-old woman lives alone in a trailer court outside a southern Missouri town. She is blind and has become too weak to lift a jug of water.*
- *A man in his sixties, who was once left bound hand and foot in a car by his caretakers, signs over his pension check to them each month because he is afraid they o herwise would turn him out.*
- *A 77-year-old man is chronically depressed and disoriented from the interaction of excessive dosages of medication being given to him by another person charged with his care.*

These are only three of the estimated 19,000 elderly Missourians who need protection from abuse, neglect, or exploitation. This guide will describe forms of abuse and situations in which it is likely to occur, and summarize the provisions of Missouri law to deal with abuse.

The law

In response to public concern, the Protective Services Law for the Elderly was passed by the Missouri General Assembly and signed by the Governor in 1980. This law is designed to assist and protect persons age 60 or older who are unable to perform or obtain essential services or to protect their own interests. The protective services provided by this law consist of visits by social workers supplemented by such community functions as visiting nurses services, homemaker services, hot meal delivery, and telephone checks. Legal intervention may also enter the picture in the form of guardianship, commitment, emergency service delivery, and protective placement.

Missouri is one of only thirteen states that has a law specifically designated to help prevent abuse and neglect of the elderly. This law establishes a system for reporting instances of abuse and neglect and provides for assistance to be given to the victims.

The Missouri Gerontology Institute develops and coordinates instruction, research and extension activities on aging among the University of Missouri campuses (Columbia, Kansas City, Rolla and St. Louis), Lincoln University, and the Missouri Cooperative Extension Service

How to report abuse or neglect

If you have reasonable cause to suspect that an elderly person is suffering serious physical harm and is in need of protective services, use the Elderly Abuse and Neglect Hotline maintained by the Department of Social Services Division of Aging. The hotline number is 1-800-392-0210.

Or, if you prefer, write the Department at:

Central Registry Unit
Division of Aging
P.O. Box 1337
Jefferson City, MO 65102

When making your report include the following information:

1. Name, age, and address of the older person in need.
2. Names and addresses of any individuals responsible for the older person.
3. The nature and extent of the older person's condition.

You are not required to give your name when making a report. If you are uncertain of how to proceed or have any questions, call the toll-free hotline number mentioned above.

Types of abuse

To assist you in identifying cases of abuse, the law describes four basic situations in which serious harm is likely to come to an individual.

1. **Self-neglect.** This situation is indicated by the elderly person's failure or inability to provide for his or her own essential needs, resulting in substantial risk that physical harm will ensue.
2. **Self-abuse.** In this situation there is reason to believe that an elderly person will inflict physical harm upon himself, as evidenced by his own actions or threats to do so.
3. **Abuse to others by an elderly person.** This situation is one in which there is a substantial risk that an elderly person will inflict physical harm upon another, as evidenced by his own actions or behavior.
4. **Abuse to elderly by others.** In this situation there is a substantial risk that further physical harm will occur to an older person who has already suffered physical injury, neglect, sexual or emotional abuse, other forms of maltreatment, or the wasting of his financial resources by another person.

The following discussion will focus on abuse to the elderly by others.

Abuse by others

A study by the Office on Aging in Bergen County, New Jersey has shown that there are four main categories of abuse to the elderly by other persons:

1. **Physical abuse.** This may take various forms, including shaking or shoving, tying the elderly person to a chair so "he won't hurt himself" while others are gone, and encouragement by the family or a physician for the elderly person to be given drugs to make him or her "manageable."
2. **Deprivation.** This is withholding life's necessities, such as food, clothing, shelter, and medical care.
3. **Financial abuse.** This involves the removal of money or real estate from the older person's control when it is not necessary for the good of the individual to do so.
4. **Emotional abuse.** This includes such things as verbal abuse (excessive criticism or unrealistic demands), forcing the elderly person to change his or her residence, and infantilization (denying the older person the right to be treated as an adult, to be informed about his or her own health condition, to participate in family and social situations, and so forth). Emotional abuse is covered by the Protective Services Law only when there is evidence of physical harm resulting from the emotional abuse. Such problems as ulcers and high blood pressure are evidence of such physical harm.

What happens after you report

If you make a report of abuse or neglect, a local social service worker will visit the older person's residence to evaluate the situation. In emergency cases this visit will be made within twenty-four hours; in less severe cases a maximum of thirty days is permitted.

By reporting abuse or neglect you will not be forcing an older person to accept services he or she does not want. The Protective Services Law states that if an elderly person does not consent to receive protective services, those services will not be given; and if the elderly person withdraws consent previously given, the services will be discontinued. The only exceptions are those cases in which there is reason to believe that the older person lacks the capacity to consent. In such instances the director of the Department of Social Services may seek a court order.

Abusers cannot interfere

In some abuse cases, an abuser may refuse to allow anyone to visit the person being abused. In such instances the Department of Social Services may petition the court for a warrant. The Department may also petition the court to forbid anyone from interfering with the delivery of services to the elderly person.

If an older person is unable to give consent

If a case is one of self-neglect or self-abuse and the older person is unable to give consent for assistance, the Department of Social Services may initiate proceedings to provide the necessary protective services.

When the police are involved

In some instances it is necessary for the police to become involved in protective cases. If a police officer believes that an older person is in immediate danger, he or she may arrange for that person to be taken to a medical facility for emergency treatment. If the police officer is barred from entering by someone in the home, the officer may apply for a court warrant to enter and remove the elderly person to the medical facility.

When medical treatment is necessary

Sometimes when an elderly person has been admitted to the hospital as a result of abuse, the relative or guardian refuses to give consent for medical treatment and the elderly person himself is unable to give consent. In these cases the head of the medical facility may file a court petition for authorization of treatment, and the court may appoint a temporary guardian to oversee the treatment. In life-threatening situations in which immediate medical treatment is needed, such treatment may be given by the facility before a court hearing is held.

Once again, it should be emphasized that the rights of the competent elderly person shall be maintained—and these rights include the right to refuse medical care on the basis of religious faith or conviction.

Characteristics of abusers and abused

To prevent incidents of abuse it is necessary to understand the common characteristics of abusers, the abused, and situations in which abuse is most likely to occur.

The abused and their situations

The older the individual the more likely he or she is to be abused; reported cases of abuse are most common among people over 75 years of age. Persons become not only physically weaker with age but also more psychologically dependent due to such aging-related changes as loss of usefulness, loss of social standing, and loss of contact with friends. Since some older persons are not only weak but also physically or mentally impaired, they are sometimes treated as children or, even worse, as less than human. It is in such situations that abuse is most likely to occur.

Abused elderly usually are living with relatives and the most frequent abusers are the offspring. A situation in which the elderly person lives with his or her child can bring out deep-seated emotional responses in the offspring who may find it difficult to accept the parent's dependency. The parent may in turn sense this stress on the offspring's part and try to demonstrate his strength and independence by taking on tasks beyond his ability. The result is often failure, tension, and frustration. Additionally, if grandchildren are in the family, the elder may attempt to parent them, causing conflicts over discipline, household procedures, and lifestyles.

In our society, for complex and diverse reasons, abuse of the elderly is most common in white families, and females tend to be abused more than males.

While abused older persons are found among all income levels, middle-class elderly experience more abuse than upper or lower-class elderly. This can be attributed to the emphasis which the middle-class puts on the work ethic and the resultant tendency of retired persons to view themselves as useless and unproductive—a view which may be subconsciously or consciously shared by other family members. Moreover, middle-class family members are more likely to separate and live long distances from each other as the children marry and move away, often to other cities.

If elderly parents eventually come to live with their children it is often a shock for the children to observe the changes that have occurred since they last visited. To observe these changes all at once and to have to cope with them daily puts stress on both parents and children. By contrast, if a parent is living with or near the child as old age approaches, as is not uncommon in lower-class families, there can be gradual adjustments made as changes occur in the parent.

The abusers

Abusers tend to be middle-aged offspring who are looking forward to freedom and relax-

ation in the form of retirement and the departure of their own children from the home. An elderly parent moving into the household represents an intrusion into their plan, and the economic drain can be extremely stressful if there are still dependent children living at home.

Abusers tend to be female, since the responsibility of caring for an elderly parent typically falls upon a daughter. Because middle-aged women are likely to be working, many find it difficult to fit caregiving into their schedules, thus adding to the personal as well as financial pressures.

Many abusers were abused as children. On the other hand, abused elderly tend to deny that they are abused because they are ashamed to admit that their own children are abusers. They also may fear that they will be compelled to move to another setting if they report abuse, or that any complaint will lead to further abuse.

Guidelines for action

Being alert to potential abuse situations, and being willing to report abuse incidents, are two good ways to help curtail abuse in Missouri. However, further preventive measures can be taken on a community basis which would go far in this regard. The following measures are both possible and essential for the well-being of many older persons and their families.

1. Education projects should be established for the families of elderly persons, particularly middle-aged offspring who either now take care of their parents or are likely to in the future. Middle-aged children must be educated on the physical and psychological changes that come about with the aging process and the best ways of dealing with them.
2. Training projects for social service personnel should be initiated to increase their effectiveness in dealing with abuse and neglect. The training should instruct them in recognizing the signs of a potential abuse situation, and train them in early intervention and in helping both the elderly and families. Such sensitivity and alertness is especially needed in cases of frail elderly persons living alone. Service personnel in a position to observe the condition of such frail elderly include visiting nurses, county health nurses, homemaker aides, physicians, clergymen, meals-on-wheels drivers, friendly visitors, outreach workers from community agencies and county councils on aging, and so forth.
3. Networks of supportive services should be established for families and elderly who live in situations where abuse or neglect has already occurred. Such services would strive to prevent further abuse by alleviating the problems which led to the abuse.

A detailed copy of the legislation itself may be obtained by writing to the Division of Aging, P.O. Box 1337, Jefferson City, MO 65102.

Through adult education and the strengthening of community voluntary support systems, we may minimize the occasions when the law must be used. Always, but particularly in this area, an ounce of prevention is worth a pound of legal care.

SECTION ANALYSIS OF HOUSE CS FOR CS FOR SB 122 (HESS)

Section 1 Purpose.

Section 2 (a) Lists professional people who are required to report suspected cases of harm of an elderly person to the Department of Health and Social Services.

(b) Lists information to be provided to the Department when a report of harm is made.

(c) "violation" is a noncriminal offense punishable by a fine, but not by imprisonment or other penalty; conviction of a violation does not give rise to any disability or legal disadvantage based on conviction of a crime; a person charged with a violation is not entitled:

(A) To a trial by jury; or
(B) To have a public defender or other counsel appointed at public expense to represent him;

(d) The bill does not preclude a person not listed, or a person listed when in a non-professional capacity, from reporting.

(e) Reports can be made to a peace officer or VPSO if immediate action is necessary. The officer will take immediate protective actions and report to the Department as soon as possible.

(f) Provides immunity from liability to a person making a good faith report.

(g) Provides that there is no civil liability for those failing to report other than provided by law.

ACTIONS ON REPORTS

(a) Requires prompt action by the Department to investigate the need for action and services. The Department shall personally interview the elderly person unless the person is unconscious or incompetent.

(b) Requires the Department to prepare a written report on findings, recommendations and the determination of action. The reporter may receive information on the investigation on request. Confirmed reports shall be forwarded to the Department of Law.

(c) Investigation shall terminate upon the request of the elderly person unless determined incapacitated, whereby the Department may petition the court to have a guardian appointed.

PROTECTIVE SERVICES

(a) The Department shall provide available protective services if the person consents, or if that person is incapacitated, may petition the court to appoint a guardian.

(b) If a caretaker is preventing the elderly person from receiving services, the Department may assist the person in petitioning the court for an injunction..

REVIEW AND REFERRAL. Provides that the Department shall review the case every 90 days until closed.

CONFIDENTIALITY OF REPORTS.

(a) Provides that reports are confidential although reports may be used by governmental agencies for investigations and judicial proceedings.

(b) A report shall be disclosed if the elderly person consents in writing. The number of verified reports occuring in an institution for the elderly may be disclosed upon request.

AUTHORITY OF THE DEPARTMENT. Provides that the Department, subject to the person's consent, initiate protective actions.

REGULATIONS. Gives the Department the authority to promulgate regulations upon approval of the Older Alaskans Commission.

QUARTERLY REPORT. The Department shall provide a quarterly statistical report on protection of the elderly to the Older Alaskans Commission.

DEFINITIONS.

ANALYSIS OF SB 122 - RELATING TO PROTECTION OF THE ELDERLY

SECTION 1 PURPOSE

SECTION 2 a) LISTS PROFESSIONAL PEOPLE REQUIRED TO REPORT CASES OF SUSPECTED ABUSE, NEGLECT OR ABANDONMENT OF AN ELDERLY PERSON

b) LISTS INFORMATION TO BE PROVIDED TO THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WHEN REPORTING.

c) "VIOLATION" IS A NONCRIMINAL OFFENSE PUNISHABLE BY A FINE, BUT NOT BY IMPRISONMENT OR OTHER PENALTY; CONVICTION OF A VIOLATION DOES NOT GIVE RISE TO ANY DISABILITY OR LEGAL DISADVANTAGE BASED ON CONVICTION OF A CRIME; A PERSON CHARGED WITH A VIOLATION IS NOT ENTITLED:

(A) TO A TRIAL BY JURY; OR
(B) TO HAVE A PUBLIC DEFENDER OR OTHER COUNSEL APPOINTED AT PUBLIC EXPENSE TO REPRESENT HIM;

d) THE BILL DOES NOT PRECLUDE A PERSON NOT LISTED, OR A PERSON LISTED WHEN IN A NON-PROFESSIONAL CAPACITY, FROM REPORTING.

e) REPORTS CAN BE MADE TO A PEACE OFFICER IF IMMEDIATE ACTION IS NECESSARY.

f) IMMUNITY FROM LIABILITY TO THE REPORTING PERSON IS GRANTED.

SEC. 47.24.020

a) REQUIRES PROMPT INVESTIGATION BY THE DEPARTMENT TO ASSESS THE NEED FOR ACTION AND SERVICES.

b) REQUIRES TO DEPARTMENT TO PREPARE A WRITTEN REPORT ON FINDINGS, RECOMMENDATIONS AND DETERMINATION OF ACTION. REPORTER MAY RECEIVE A COPY ON REQUEST.

c) INVESTIGATION WILL TERMINATE UPON REQUEST OF THE ELDER PERSON UNLESS THEY ARE INCAPACITATED, WHEREBY THE DEPARTMENT MAY PETITION THE COURT TO HAVE A GUARDIAN APPOINTED.

SEC. 47.24.030

a)THE DEPARTMENT SHALL PROVIDE PROTECTIVE SERVICES AT THE CONSENT OF THE ELDER PERSON, OR IF THAT PERSON IS INCAPACITATED, THE DEPARTMENT MAY PETITION THE COURT TO APPOINT A GUARDIAN.

b) THE DEPARTMENT MAY DISCLOSE THE REPORT AT THE REQUEST OF THE ELDER PERSON, AND , ON REQUEST, DISCLOSE REPORTS OF HARM AT AN INSTITUTION CERTIFIED BY THE STATE.

SEC. 47.24.060 - LISTS ACTIONS AVAILABLE TO THE DEPARTMENT TO SAFEGUARD AN ELDERLY PERSON.

SEC. 47.24. 070 - GIVES THE DEPARTMENT AUTHORITY TO PROMULGATE REGULATIONS, APPROVED BY THE OLDER ALASKANS COMMISSION.

SEC. 47.24.075 - EXCLUDES THE PHYSICIAN-PATIENT AND HUSBAND-WIFE RELATIONSHIPS AS GROUNDS FOR EXCLUDING EVIDENCE.

SEC. 47.24.080. - QUARTERLY REPORTS WILL BE MADE TO THE OLDER ALASKANS COMMISSION OF STATISTICS CONCERNING THIS BILL, NOT TO INCLUDE THE IDENTITY OF VICTIMS OR PERPETRATORS.

SEC. 47.24.100 - DEFINITIONS

OLDER ALASKANS COMMISSION
POSITION PAPER

Senate Bill 122 / House Bill 192
"An Act relating to protection of the elderly"

The Older Alaskans Commission urges passage of this legislation in order to provide protection and assistance to older persons who are unable to care for themselves.

Twenty other states currently have mandatory reporting laws for elderly abuse. During the past year both Delaware and New Mexico have passed this type of legislation. The Commission feels that mandatory reporting is essential in order to reach vulnerable persons who may be physically, psychologically or financially unable to help themselves.

Historically elder abuse has been a hidden social problem but it is one that is encounterered statewide by Commission funded senior projects. The Commissions senior ombudsman program received sixteen reports of abuse during FY 1982.

In 1981 the Administration on Aging funded a study of elder abuse in Anchorage through the Commission. Twenty agencies surveyed by the Anchorage Community Health Center for this study reported contacts with elder abuse cases. Seventy-five cases of elder abuse were reported in all. In 75% of these cases, the abuse had been going on for some time. In 53% of the cases the victims did seek help. The remaining victims who did not seek help are significant to the passage of this legislation.

The Commission recommends that "willful" be inserted before "deprivation" under Definitions, Sec. 47.24.100, (2) line 25. The purpose of this insertion is to ensure that poverty and other circumstances beyond a caretaker's control will not be considered as abuse. Staff also questions the intent of line 13 in Section 47.24.020 which states "The Department shall make every reasonable effort to personally interview the elderly person during the investigation". This could be construed to imply that the Department could make decisions about an abused person without contacting him.

The Commission is aware that a major criticism of elderly abuse mandatory reporting laws is that the necessary services may not be in place to meet the demand for them. The Commission does not concur. Elder abuse is not a problem that can denied or ignored. We hope to work closely with DFYS to assist in putting those necessary services in place.

We ask your support of this bill and in making the health and dignity of our elderly a major state priority.

Prepared by: _____ Date:
Jon Wolfe

Commissioner's Office Review by: Lisa S Rudd Date: 3/10/83
Lisa Rudd, Commissioner

3/4/83

JOE P. JOSEPHSON
DISTRICT G · ANCHORAGE
1526 F STREET
ANCHORAGE, ALASKA 99501
(907) 277-4419

COMMITTEES
HEALTH, EDUCATION & SOCIAL SERVICES (CHAIR)
JUDICIARY (VICE-CHAIR)
FINANCE
MAJORITY CAUCUS (CHAIR)

ALASKA STATE SENATE

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4907
(907) 465-4525

M E M O R A N D U M

TO: Billy Barrier

FROM: Joe P. Josephson

RE: SB 122

DATE: March 7, 1983

Concern was expressed that the section (47.24.075) which states that the physician-patient privilege is not ground for excluding evidence regarding an elderly person's harm is unwise or unnecessary. First, the privilege may exist as part of court rules, and the inclusion of this provision could require passage by a two thirds majority vote. Second, the privilege is in actuality the privilege of the patient. The statutory repeal of the privilege in these cases could mean that the medial history and records of the patient -- notwithstanding the patient's desire for confidentiality -- could be released at the instance of the physician.

I would appreciate your comments about the privilege and the background, as you understand it, for the section as proposed.

While the reference to the husband-wife privilege did not draw comment, any observations you may have about that reference would also be welcome.

STATE OF ALASKA
FISCAL NOTE

Revision Date 3/23 , 1983

I. REQUEST

Bill/Resolution No.: CSSB 122
Title: Protection of the Elderly
Sponsor: Josephson
Requestor:

II. FISCAL DETAIL

Agency Affected: H&SS
Program Category Affected: Social Services
BRU, Program of Subprogram(s) Affected:
Program Services BRU, Adult Services

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		7.5	8.0	8.4	8.9	9.5
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC		10.0	10.6	11.2	11.9	12.6
TOTAL OPERATING		17.5	18.6	19.6	20.8	22.1
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		17.5	18.6	19.6	20.8	22.1
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS:

FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

The source of funds was not identified by the sponsors.

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Michael L. Price, Director Phone: 465-3170
Division: Family and Youth Services Date: 3/23/83

Approved by Commissioner: Robert Loulon Smith Date: 3/30/83
Department: H. & S.S.

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/83

POSITION PAPER

CS FOR SENATE BILL NO. 122 (HESS)
PAGE 1

"An Act relating to protection of the elderly."

OVERVIEW

This Bill includes provisions for mandatory reporting of cases of physical harm to elderly persons, investigation of reports of harm by the Department of Health and Social Services, and the offering of appropriate protective services to elderly persons in an effort to prevent or alleviate physical harm.

STATEMENT OF THE PROBLEM

In the past few years there has been increasing awareness across the nation, including Alaska, of the problems of elder abuse and neglect, as well as those elderly persons who are unable to protect or care for themselves. In 1981 an Elder Abuse Task Force was created in Anchorage and a pilot project grant was awarded to the Anchorage Community Mental Health Clinic Geriatric Unit to address the issue of elder abuse. In 1982, Elder Abuse Task Forces were created in Fairbanks and Juneau.

Elderly Alaskans in need of protective services are served by the Division of Family and Youth Services under its Adult Protective Service program which serves adults age 18 and over. Adult Protective Services are provided on a voluntary basis by a mandate under Title XX of the Social Security Act. Division social workers respond to voluntary reports of harm, investigate the circumstances of abuse, neglect, and exploitation, and offer appropriate protective services. If an adult client does not consent to services and is not incapacitated as defined under AS 13.26.005, the guardianship statute, the Division has no legal authority to intervene. If, however, an investigation indicates that an adult is incapacitated, the Division may petition the court for a guardian.

Division of Family and Youth Services' staff have actively participated in the Elder Abuse Task Forces. As a part of the Division's Fiscal Year 1983 Adult Protective Services Training Program, the issues of elder abuse, guardianship and conservatorship have been addressed. Community agencies, including programs serving older Alaskans, were invited and participated in these sessions which were conducted in Anchorage, Bethel, Fairbanks, Juneau, Ketchikan, and Nome.

Since reporting of abuse or physical harm to elderly persons is not mandatory, not all known cases are reported to a single agency. As a result, the actual extent of the problem is not known. Should the

number of cases reported under the mandatory requirement significantly impact caseloads, the Division will include necessary documentation to support the need for additional staff and service dollars in the FY 85 budget. If Additional staff and service dollars become necessary but not available, the Division may not be able to meet the intent of the legislation.

RECOMMENDATION

The Department strongly endorses efforts to promote the independence and well-being of those elderly persons in need of protection. The procedures outlined in the Bill for action on reports, provision of protective services, review and referral, and confidentiality are in accordance with procedures established by the Department of Health and Social Services.

RECOMMENDED: Michael L Price
Michael L. Price, Director
Division of Family and
Youth Services

DATE: March 25, 1983

APPROVED BY: Robert London Smith
Robert London Smith, Ph.D.
Commissioner

DATE: 3/30/83

IV. ANALYSIS

A. Assumptions

Passage of this Bill would necessitate educating the public through the news media and handouts. Regulations would need to be promulgated. These functions would be performed by existing staff. Without historical data for reporting abuse, neglect, or abandonment, the assumption is made that one-half again as many situations reported would result in placement, and counseling with both the individual and the family.

B. Program Summary

1. No new positions would be required.

2. Contractual Services includes costs for printing regulations and for news media public educational announcements. Benefits to individuals includes special needs items for adult clients such as fuel supply and transportation to and from necessary services.

C. Computations

Estimates for Contractual are based upon similar previous costs. The estimates for Benefits to Individuals does not reflect a formula as there is no previous history upon which to base costs.

D. Economic Impact

Enactment will help prevent or alleviate physical harm to the elderly, and will promote their ability to remain independent.

E. Impact on Local Governments

There will be no fiscal impact on local governments.

CS SB 122 (HESS) - PROTECTION OF THE ELDERLY

ABUSE OF THE ELDERLY IS RECOGNIZED AS A PROBLEM IN ALASKA AS ILLUSTRATED BY THE STUDY ON ELDER ABUSE COMPLETED BY THE ANCHORAGE COMMUNITY MENTAL HEALTH CENTER.

THE STUDY DOCUMENTED 75 CASES, FINDING 43.3% OF PHYSICAL ABUSE, 70% OF PSYCHOLOGICAL ABUSE, 57.3% OF MATERIAL ABUSE AND 24% VIOLATION OF RIGHTS IN THE CONTROL GROUP.

IN ATTEMPT TO DEAL WITH THIS PROBLEM, THIS BILL HAS BEEN DRAFTED MUCH AS THE CHILD PROTECTION STATUTES, WITH THE INTENT TO FIT INTO THE SYSTEM ALREADY ESTABLISHED FOR CHILDREN.

THIS BILL PROVIDES FOR MANDATORY REPORTING OF SUSPECTED ABUSE BY PROFESSIONALS, SETS OUT THE PROCEDURES FOR REPORTING FOR THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WITH REPORTS FORWARDED FOR REVIEW TO THE DEPARTMENT OF LAW, PROTECTS THE RIGHTS OF THE ELDER PERSON, ALLOWS THE APPOINTMENT OF GUARDIANS, LISTS ACTIONS AVAILABLE TO THE STATE FOR PROTECTION, GIVES THE DEPARTMENT AUTHORITY TO PROMULGATE REGULATIONS, AND PROVIDES FOR REPORTS ON ELDER ABUSE TO BE CREATED TO DOCUMENT PROBLEMS.

SINCE THIS PROGRAM CAN FIT INTO THE EXISTING SYSTEM ALREADY ESTABLISHED FOR THE PROTECTION OF CHILDREN, THE FISCAL NOTE REFLECTS A COST OF ONLY $17,500.

EIGHT PEOPLE FROM ORGANIZATIONS DEALING WITH SENIOR CITIZENS TESTIFIED BEFORE THE SENATE HESS COMMITTEE IN SUPPORT OF THIS BILL, AND IT IS A PRIORITY OF THE OLDER ALASKANS COMMISSION AND SUPPORTED BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES.

IT IS TIME THAT WE RECOGNIZE THE SERIOUSNESS OF THE PROBLEMS OF ABUSING THE ELDERLY, AND WE MUST REALIZE THAT IN MANY INSTANCES THEY ARE AS HELPLESS AS CHILDREN WHO ARE ALSO ABUSED

MEMORANDUM

TO: JOE
FROM: NANCY
RE: HCS FOR CS SB 122 (HESS)

THE FOLLOWING CHANGES WERE MADE IN THE HOUSE HESS COMMITTEE:

PAGE 1, LINES 13-14:

LANGUAGE WAS ADDED TO REQUIRE REPORTS REGARDLESS OF ANY EVIDENTIARY PRIVILEDGES ESTABLISHED BY STATE LAW OR THE ALASKA RULES OF COURT.

PAGE 2, LINES 15-16:

ADDED A NEW SUBSECTION TO THE PROFESSIONALS REQUIRED TO REPORT ELDER ABUSE IN THEIR PROFESSIONAL CAPACITY:

(13) an emergency medical technician or paramedic in the mobile intensive care program.

PAGE 3, LINE 18:

Added to subsection (g) (failure to make a report is not the basis for civil liability) a reference to subsection (d) which provides that no person is prohibited from reporting abuse if not listed in the required reporting section, and that a professional person is not prohibited from reporting when abuse is observed while in a non-professional capacity.

PAGE 4, LINE 7:

ADDS LANGUAGE TO SUBSECTION (b) TO PROVIDE THAT ONLY CONFIRMED REPORTS WILL BE FORWARDED TO THE DEPARTMENT OF LAW FOR REVIEW.

PAGE 6. LINE 19:

CHANGED THE AGE OF AN ELDERLY PERSON FROM 60 TO 65.

PAGE 7, LINE 2:

IN THE DEFINITION OF "PHYSICAL HARM", REMOVED THE RESTRICTION THAT THE INJURY RESULT FROM ACTIONS OF A CARETAKER, SO THAT ANY PERSON WHO HARMED AN ELDERLY PERSON COULD BE REPORTED.

"An Act relating to protection of the elderly."

OVERVIEW

This Bill includes provisions for mandatory reporting of cases of physical harm to elderly persons, investigation of reports of harm by the Department of Health and Social Services, and the offering of appropriate protective services to elderly persons in an effort to prevent or alleviate physical harm.

STATEMENT OF THE PROBLEM

In the past few years there has been increasing awareness across the nation, including Alaska, of the problems of elder abuse and neglect, as well as those elderly persons who are unable to protect or care for themselves. In 1981 an Elder Abuse Task Force was created in Anchorage and a pilot project grant was awarded to the Anchorage Community Mental Health Clinic Geriatric Unit to address the issue of elder abuse. In 1982, Elder Abuse Task Forces were created in Fairbanks and Juneau.

Elderly Alaskans in need of protective services are served by the Division of Family and Youth Services under its Adult Protective Service program which serves adults age 18 and over. Adult Protective Services are provided on a voluntary basis by a mandate under Title XX of the Social Security Act. Division social workers respond to voluntary reports of harm, investigate the circumstances of abuse, neglect, and exploitation, and offer appropriate protective services. If an adult client does not consent to services and is not incapacitated as defined under AS 13.26.005, the guardianship statute, the Division has no legal authority to intervene. If, however, an investigation indicates that an adult is incapacitated, the Division may petition the court for a guardian.

Division of Family and Youth Services' staff have actively participated in the Elder Abuse Task Forces. As a part of the Division's Fiscal Year 1983 Adult Protective Services Training Program, the issues of elder abuse, guardianship and conservatorship have been addressed. Community agencies, including programs serving older Alaskans, were invited and participated in these sessions which were conducted in Anchorage, Bethel, Fairbanks, Juneau, Ketchikan, and Nome.

Since reporting of abuse or physical harm to elderly persons is not mandatory, not all known cases are reported to a single agency. As a result, the actual extent of the problem is not known. Should the

number of cases reported under the mandatory requirement significantly impact caseloads, the Division will include necessary documentation to support the need for additional staff and service dollars in the FY 85 budget. If Additional staff and service dollars become necessary but not available, the Division may not be able to meet the intent of the legislation.

RECOMMENDATION

The Department strongly endorses efforts to promote the independence and well-being of those elderly persons in need of protection. The procedures outlined in the Bi[illegible] for action on reports, provision of protective services, review and referral, and confidentiality are in accordance with procedures established by the Department of Health and Social Services.

RECOMMENDED: Michael L Price
Michael L. Price, Director
Division of Family and
Youth Services

DATE: March 25, 1983

APPROVED BY: Robert London Smith
Robert London Smith, Ph.D.
Commissioner

DATE: 3/30/83

FISCAL NOTE Revision Date 3/25, 1983

I. REQUEST
Bill/Resolution No.: CSSB 122
Title: Protection of the Elderly
Sponsor: Josephson
Requestor:

II. FISCAL DETAIL
Agency Affected: H&SS
Program Category Affected: Social Service
BRU, Program of Subprogram(s) Affected: Program Services BRU, Adult Services

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		7.5	8.0	8.4	8.9	9.5
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC		10.0	10.6	11.2	11.9	12.6
TOTAL OPERATING		17.5	18.6	19.6	20.8	22.1
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		17.5	18.6	19.6	20.8	22.1
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS:

FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

The source of funds was not identified by the sponsors.

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Michael L. Price, Director Phone: 465-3170
Division: Family and Youth Services Date: 3/23/83

Approved by Commissioner: Robert London Smith Date: 3/30/83
Department: H & S.S.

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/

IV. ANALYSIS

A. Assumptions

Passage of this Bill would necessitate educating the public through the news media and handouts. Regulations would need to be promulgated. These functions would be performed by existing staff. Without historical data for reporting abuse, neglect, or abandonment, the assumption is made that one-half again as many situations reported would result in placement, and counseling with both the individual and the family.

B. Program Summary

1. No new positions would be required.

2. Contractual Services includes costs for printing regulations and for news media public educational announcements. Benefits to individuals includes special needs items for adult clients such as fuel supply and transportation to and from necessary services.

C. Computations

Estimates for Contractual are based upon similar previous costs. The estimates for Benefits to Individuals does not reflect a formula as there is no previous history upon which to base costs.

D. Economic Impact

Enactment will help prevent or alleviate physical harm to the elderly, and will promote their ability to remain independent.

E. Impact on Local Governments

There will be no fiscal impact on local governments.

BILL SHEFFIELD, GOVERNOR

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE:

DOCUMENT NO._____

Honorable Don Bennett
Co-Chairman of Senate
Finance Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Bennett:

The following information is being provided in response to questions raised at the Senate Finance Hearing on April 7, 1983, on CS for Senate Bill No. 122 (HESS).

The Division of Family and Youth Services' Adult Protective Service program consists of the provision of supportive and/or protective services for adults age 18 and over who are not able to function independently, or who may be subject to abuse, neglect or exploitation. The Department does not have specific statutory authority to intervene in situations in which an adult may be at risk of harm. Adult Protective Service is provided with client consent under the adult protective service goal of Title XX of the Social Security Act and the general powers and duties of the Department to promote the health and well-being of Alaskans.

Social workers respond to referrals and reports of harm by contacting the adult, conducting an assessment/investigation to determine the validity of the report or the nature of the client's needs, providing social work services, making referrals and arranging for appropriate and available services. Services are provided with the consent of the client. Services are purchased by the Division on an individual client basis and include homemaker support, residential care and foster care. Services to which clients are referred include transportation, congregate meals, home delivered meals, home health aide services, medical services, legal services, and mental health services.

As of April 7, 1983, the Division of Family and Youth Services Adult Protective Service caseload was 1,055 clients, of whom 698 are age 60 and over. Of those clients age 60 and over, services to 446 clients or 64% were directed to the goal of preventing or remedying neglect, abuse or exploitation. The Division of Family and Youth Services Case Management Information System does not currently separate out these categories.

06-F38LH

Data are not available on the total dollars spent on elder abuse cases, including social work services. However, the following are the amounts spent on purchased services for clients age 60 and over with preventing or remedying abuse, neglect, or exploitation as the service goal for the period July 1, 1982, through April 8, 1983, for homemaker support, adult foster care and adult residential care.

Homemaker Support	$634,056
Residential Care	$ 20,321
Foster Care	$ 1,048
Total	$655,425

3 additional responsibilities

If CS for Senate Bill No. 122 (HESS) is passed, in addition to charging the Department with the duty to investigate elder abuse, the Department will have the following additional responsibilites:

1. Section 47.24.020(c) mandates the Department to provide to the Department of Law a copy of each report of an investigation of harm to an elderly person that resulted from abuse;

2. Section 47.24.070 authorizes implementation of regulations; and,

3. Section 47.24.075 mandates that the Department submit a quarterly statistical report of the Department's activities related to protection of the elderly to the Older Alaskans Commission.

As indicated in the Department's Position Paper on this Bill, since reporting of physical harm to elderly persons is not mandatory, not all known cases are necessarily reported to the Division of Family and Youth Services. As a result the actual extent of the problem is not known. In addition, individuals who are aware of situations in which an elderly person is being abused may be reluctant to report the harm because there is no statutory provision for immunity from civil or criminal liability.

+ MANDATE Reporting of physical harm

Section 47.24.010(a) of the Bill mandates reporting cases involving elderly persons who have been or who are being physically harmed. If the Bill had mandated reporting of other forms of abuse as well as neglect and abandonment and had required the provision of specific supportive services, the Department would have determined that such requirements would have a substantial fiscal impact.

Last legislative Bill was Brought

During the Twelfth Legislature, Bills were introduced on elder abuse which would have given the Department of Health and Social Services a broad mandate regarding protection of the elderly and would have required the creation of additional services. The Department's Fiscal Note reflected the broad mandate and was $1.3 million.

As noted in the Department's Position Paper on this Bill, should the number of cases reported under the mandatory requirement significantly impact caseloads, the Division will include necessary documentation to support the need for additional staff and service dollars in future operating budget requests. If additional staff and service dollars become necessary but not available, the Department may not be able to meet the intent of the legislation.

The inclusion of $10,000 for benefits to individuals in the Department's Fiscal Note on this Bill is for services which may be needed for an elder abuse victim for which there is no other resource, e.g., for individuals who are not eligible for General Relief or for whom the $80 per month available through General Relief is not adequate. In addition, the Department's Fiscal Year 1984 budget does not include funds for expansion of existing programs for Adult Protective Service clients. Currently there are waiting lists for homemaker support in some communities; and there are a limited number of residential care beds for the elderly located in Anchorage only.

I hope this information is of assistance to you. If you have any additional questions, please contact me.

Sincerely,

Robert London Smith, Ph.D.
Commissioner

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

CS FOR SENATE BILL NO. 122 (Judiciary)
PAGE 1

RECEIVED

Josephson,

"An Act relating to protection of the elderly."

OVERVIEW

This Bill includes provisions for mandatory reporting of cases of physical and economic harm to elderly persons, investigation of reports of harm by the Department of Health and Social Services, and the offering of appropriate protective services to elderly persons in an effort to prevent or alleviate economic and physical harm. In addition to charging the Department with the duty to investigate reports of harm, the Department will have the following additional responsibilities if this Bill is passed.

1. Section 47.24.020(b) mandates the Department to provide to the Department of Law a copy of each report of an investigation of harm to an elderly person;

2. Section 47.24.070 authorizes the implementation of regulations to be approved by the Older Alaskans Commission before adoption by the Department; and

3. Section 47.24.075 mandates that the Department submit to the Older Alaskans Commission a quarterly statistical report of the Department's activities related to protection of the elderly.

STATEMENT OF THE PROBLEM

In the past few years there has been increasing awareness across the nation, including Alaska, of the problems of elder abuse, neglect, and exploitation and elderly persons who are unable to protect or care for themselves. In 1981 an Elder Abuse Task Force was created in Anchorage and a pilot project grant was awarded to the Anchorage Community Mental Health Clinic Geriatric Unit to address the issue of elder abuse. In 1982, Elder Abuse Task Forces were created in Fairbanks and Juneau.

Elderly Alaskans in need of protective services are served by the Division of Family and Youth Services under its Adult Protective Service program which serves adults age 18 and over who are not able to function independently or who may be subject to abuse, neglect, or exploitation. Adult Protective Services are provided on a voluntary basis by a mandate under Title XX of the Social Security Act and the general powers and duties of the Department to promote the health and well-being of Alaskans. Division social workers respond to voluntary reports of harm, investigate the circumstances of abuse, neglect, and exploitation, and

RECEIVED
MAY 25 1983
Josephson,

offer appropriate protective services. If an adult client does not consent to services and is not incapacitated as defined under AS 13.26.005, the guardianship statute, the Division has no legal authority to intervene. If, however, an investigation indicates that an adult is incapacitated, the Division may petition the court for a guardian.

As of April 7, 1983, the Division of Family and Youth Services Adult Protective Service caseload was 1,055 clients, of whom 698 are age 60 and over. Of those clients age 60 and over, services to 446 clients or 64% were directed to the goal of preventing or remedying neglect, abuse or exploitation. The Division of Family and Youth Services Case Management Information System does not currently separate out these categories.

Division of Family and Youth Services' staff have actively participated in the Elder Abuse Task Forces. As a part of the Division's Fiscal Year 1983 Adult Protective Services Training Program, the issues of elder abuse, guardianship and conservatorship have been addressed. Community agencies, including programs serving older Alaskans, were invited and participated in these sessions which were conducted in Anchorage, Bethel, Fairbanks, Juneau, Ketchikan, and Nome.

Since reporting of harm to elderly persons is not mandatory, not all known cases are reported to a single agency. As a result, the actual extent of the problem is not known. However, we anticipate that mandatory reporting of physical and economic harm will result in increased caseloads. Social worker caseloads are such that additional staff will be necessary to meet the intent of this Bill. Furthermore, should the number of cases reported under the mandatory requirement significantly impact caseloads more than is anticipated, the Division will include necessary documentation to support the need for additional staff and service dollars in the FY 85 budget. If additional staff and service dollars become necessary but not available, the Division may not be able to meet the intent of the legislation.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

CS FOR SENATE BILL NO. 122 (Judiciary)
PAGE 2.1

RECOMMENDATION

The Department strongly endorses efforts to promote the independence and well-being of those elderly persons in need of protection. The procedures outlined in the Bill for action on reports, provision of protective services, review and referral, and confidentiality are in accordance with procedures established by the Department of Health and Social Services.

RECOMMENDED: for Suzanne Ederer Wheeler
Michael L. Price, Director
Division of Family and
Youth Services

DATE: May 18, 1983

APPROVED BY: Robert London Smith
Robert London Smith, Ph.D.
Commissioner

DATE: 5/24/83

STATE OF ALASKA
FISCAL NOTE

Revision Date 5/17 , 1983

I. REQUEST

Bill/Resolution No.: CSSB 122
Title: "...protection of the elderly."
Sponsor: Josephson and V. Fischer
Requestor: Judiciary

II. FISCAL DETAIL

Agency Affected: Health & Social Services
Program Category Affected:
BRU, Program of Subprogram(s) Affected:

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES		210.0	222.5	236.0	250.2	265.2
200 TRAVEL		8.4	8.9	9.4	10.0	10.6
300 CONTRACTUAL		10.4	11.0	11.7	12.4	13.1
400 COMMODITIES		1.8	1.9	2.0	2.1	2.3
500 EQUIPMENT		6.0				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC		10.0	10.6	11.2	11.9	12.6
TOTAL OPERATING		246.6	255.0	270.3	286.6	303.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS		246.6	255.0	270.3	286.6	303.8
OTHER (Specify Source)						

POSITIONS:

FULL-TIME		2	2	2	2	2
PART-TIME		5	5	5	5	5
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Michael L. Price
Division: Family & Youth Services
Phone: 465-3170
Date: 5/17/83

Approved by Commissioner: Kathleen Smith, Ph.D.
Department: H & SS
Date: 5/24/83

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor
Copy to Requestor (if different from Sponsor)

3/8/83

IV. ANALYSIS

A. Assumptions

The establishment of mandatory reporting of cases of physical and economic harm to elderly persons would necessitate educating the public through the news media and handouts. Regulations would need to be promulgated. Without historical data for reporting abuse, neglect, or abandonment, the assumption is made that one-half again as many situations reported would result in placement and counseling with both the individual and family, which would require the establishment of permanent full-time positions in Anchorage and Fairbanks and permanent part-time positions in Juneau, Ketchikan, Nome, Bethel and Palmer.

B. Program Summary

1. Positions: The increase in caseloads would require establishing the following positions:

Social Worker III	PFT	Anchorage
Social Worker III	PFT	Fairbanks
Social Worker III	PPT	Juneau
Social Worker III	PPT	Ketchikan
Social Worker III	PPT	Nome
Social Worker III	PPT	Bethel
Social Worker III	PPT	Palmer

2. Other Expenditures:

It will be necessary to secure additional office space, copier, telephones, postage, commodities and minimal equipment for each new position. Detail of these costs are reflected on the attached forms 13. Funds will also be necessary to provide special needs for adult clients.

C. Computations

Computations are those used in the FY 84 budget with a 6% inflation factor for future years.

D. Economic Impact

Enactment will help prevent or alleviate physical harm to the elderly, and will promote their ability to remain independent.

E. Impact on Local Governments

There will be no fiscal impact on local governments.

TITLE OF INCREMENT

Protection of the elderly

EXPLAIN WHICH BRU OBJECTIVE IS AFFECTED, AND HOW.

Objective

Provide social services in the least restrictive setting to adults who are victims of abuse, neglect, or exploitation.

Effect

Reports of abuse, neglect, or abandonment of an elderly person will be investigated and appropriate services provided. Service may include information and referral, case assessment, case planning, authorizing and arranging for appropriate services and placement

4. CODE	EXPENDITURE BY OBJECT	AGENCY REQ.	GOV'S REQ.
100	Personal Services	210.0	
200	Travel	8.4	
300	Contractual Services	10.4	
400	Commodities	1.8	
500	Equipment	6.0	
600	Lands, Buildings, Etc.		
700	Grants, Claims, Etc.	10.0	
800	Miscellaneous		
	TOTAL	246.6	
	I-A Transfer (NON-ADD)		
	Federal Receipts - Code:		
	General Fund	246.6	
	Other		
5. POSITION INFORMATION	PFT	2	
	Staff Months	24	
	FTE	5	

BRIEFLY DESCRIBE WHAT THIS INCREMENT PURCHASES.

Costs for printing of regulations and for news media public educational announcements, costs for special needs for adult clients, and positions necessary to provide protective services to adults.

6. INCREMENT PRIORITY

BRU Level: _____ of _____ BRU

Agency Level: _____ of _____ Agency

7. CHECK ONE OR BOTH

[ ] Currently Existing Service

[X] New Service

8. IMPACT FROM CAPITAL PROJECT (NAME)

_____

Chapter _____ SLA _____ Page/Line _____

6 INCREMENT REQUEST

AGENCY Health and Social Services

PROGRAM Social and Economic Assistance for the General Population

BRU Program Services

COMPONENT Adult Services

FY 84

Revised Date

1.	POSITION TITLE: Social Worker III			RANGE/STEP: 16 A	BARG. UNIT: G.G.U.	FORM 12 PAGE/LINE	COV.	APPROV.	DISAPP.
2.	TYPE OF POSITION: PFT	STAFF MONTHS: 12	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION: Anchorage	ELECTION DISTRICT	LEG.		

3.	CONTINUATION LEVEL	ADDITION		
4.	TYPE OF EXPENDITURE			AMOUNT
	1		2	3
	PERSONAL SERVICES			
5.	Salary		30,876	
6.	Benefits		1,896	
7.	Supplemental Benefits		5,280	
8.	Fixed Benefits		2,880	
9.	TOTAL PERSONAL SERVICES	01		40,932
10.	Travel	02		2,000
11.	Contractual	03		1,482
12.	Commodities	04		400
13.	Equipment	05		860
14.	Other			
15.	TOTAL COST			45,674

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		G.F. Match	1003	
18.		General Funds	1004	45,674
19.		I-A Receipts	1005	
20.		Program Receipts	1028	
21.		Other		

FOR OMB USE ONLY
AA KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services
PROGRAM Social and Economic Assistance for the General Population
BRU Program Services
COMPONENT Adult Services

Page 1 of 7
Revised Date

FY 84

1.	POSITION TITLE Social Worker III			RANGE/STEP 16 A	BARG. UNIT G.G.U.	FORM 12 PAGE/LINE	COV.	APPROV.	DISAPP.
2.	TYPE OF POSITION PFT	STAFF MONTHS 12	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION Fairbanks	ELECTION DISTRICT	LEG.		
3.	CONTINUATION LEVEL	ADDITION								

4.	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
	PERSONAL SERVICES		
5.	Salary	35,580	
6.	Benefits	2,184	
7.	Supplemental Benefits	6,084	
8.	Fixed Benefits	2,880	
9.	TOTAL PERSONAL SERVICES 01		46,728
10.	Travel 02		2,000
11.	Contractual 03		1,482
12.	Commodities 04		400
13.	Equipment 05		360
14.	Other		
15.	TOTAL COST		51,470

	RECEIPT CODE	FUNDING SOURCE	
16.		Federal Receipts 1002	
17.		G.F. Match 1003	
18.		General Funds 1004	$1,470
19.		I-A Receipts 1005	
20.		Program Receipts 1023	
21.		Other	

FOR OMB USE ONLY
AA KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services
PROGRAM Social and Economic Assistance for the General Population
BRU Program Services
COMPONENT Adult Services

Revised Date

FY 84

1. POSITION TITLE				RANGE/STEP	BARG. UNIT	FORM 12 PAGE/LINE	GOV.	APPROV.	DISAPP.
Social Worker III				16 A	G.G.U.				
2. TYPE OF POSITION	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION	ELECTION DISTRICT	LEG.		
PPT	6				Palmer				

3. CONTINUATION LEVEL | ADDITION

4. TYPE OF EXPENDITURE		AMOUNT
1	2	3
PERSONAL SERVICES		
5. Salary	16,020	
6. Benefits	984	
7. Supplemental Benefits	2,736	
8. Fixed Benefits	2,880	
9. TOTAL PERSONAL SERVICES 01		22,620
10. Travel 02		800
11. Contractual 03		1,482
12. Commodities 04		200
13. Equipment 05		860
14. Other		
15. TOTAL COST		25,962

	RECEIPT CODE	FUNDING SOURCE	
16.		Federal Receipts 1002	
17.		G.F. Match 1003	
18.		General Funds 1004	25,962
19.		I-A Receipts 1005	
20.		Program Receipts 1028	
21.		Other	

FOR OMB USE ONLY
4A KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services
PROGRAM Social and Economic Assistance for the General Population
BRU Program Services
COMPONENT Adult Services

Revised Date

FY 84

1.	POSITION TITLE: Social Worker III			RANGE/STEP: 16 A	BARG. UNIT: G.G.U.	FORM-12 PAGE/LINE	GOV.	APPROV.	DISAPP.
2.	TYPE OF POSITION: PPT	STAFF MONTHS: 6	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION: Juneau	ELECTION DISTRICT	LEG.		

3.	CONTINUATION LEVEL	ADDITION

4.	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
	PERSONAL SERVICES		
5.	Salary	15,444	
6.	Benefits	948	
7.	Supplemental Benefits	2,640	
8.	Fixed Benefits	2,880	
9.	TOTAL PERSONAL SERVICES 01		21,912
10.	Travel 02		800
11.	Contractual 03		1,482
12.	Commodities 04		200
13.	Equipment 05		860
14.	Other		
15.	TOTAL COST		25,254

	RECEIPT CODE	FUNDING SOURCE	
16.		Federal Receipts 1002	
17.		G.F. Match 1003	
18.		General Funds 1004	25,254
19.		I-A Receipts 1005	
20.		Program Receipts 1028	
21.		Other	

FOR BRU USE ONLY
AA KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services
PROGRAM Social and Economic Assistance for the General Population
BRU Program Services
COMPONENT Adult Services

Revised Date

FY 84

1.	POSITION TITLE: Social Worker III			RANGE/STEP: 16 A	BARG. UNIT: G.G.U.	FORM 12 PAGE/LINE	GOV.	APPROV.	DISAPP.
2.	TYPE OF POSITION: PPT	STAFF MONTHS: 6	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION: Ketchikan	ELECTION DISTRICT	LEG.		

3.	CONTINUATION LEVEL	ADDITION		
4.	TYPE OF EXPENDITURE			AMOUNT
	1		2	3
	PERSONAL SERVICES			
5.	Salary		15,444	
6.	Benefits		948	
7.	Supplemental Benefits		2,640	
8.	Fixed Benefits		2,880	
9.	TOTAL PERSONAL SERVICES	01		21,912
10.	Travel	02		800
11.	Contractual	03		1,482
12.	Commodities	04		200
13.	Equipment	05		860
14.	Other			
15.	TOTAL COST			25,254

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		G.F. Match	1003	
18.		General Funds	1004	25,254
19.		I-A Receipts	1005	
20.		Program Receipts	1028	
21.		Other		

FOR B&M USE ONLY
4A KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services
PROGRAM Social and Economic Assistance for the General Population
BRU Program Services
COMPONENT Adult Services

Revised Date

FY 84

1.	POSITION TITLE				RANGE/STEP	BARG. UNIT	FORM 12 PAGE/LINE	GOV.	APPROV.	DISAPP.
	Social Worker III				16 A	G.G.U.				
2.	TYPE OF POSITION	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION	ELECTION DISTRICT	LEG.		
	PPT	6				Nome				

3. CONTINUATION LEVEL [ ] ADDITION [ ]

4. TYPE OF EXPENDITURE		2	AMOUNT 3
	PERSONAL SERVICES		
5.	Salary	20,364	
6.	Benefits	1,248	
7.	Supplemental Benefits	3,440	
8.	Fixed Benefits	2,880	
9.	TOTAL PERSONAL SERVICES 01		27,972
10.	Travel 02		1,000
11.	Contractual 03		1,482
12.	Commodities 04		200
13.	Equipment 05		860
14.	Other		
15.	TOTAL COST		31,514

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		G.F. Match	1003	
18.		General Funds	1004	31,514
19.		I-A Receipts	1005	
20.		Program Receipts	1028	
21.		Other		

FOR BRU USE ONLY
AA KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services
PROGRAM Social and Economic Assistance for the General Population
BRU Program Services
COMPONENT Adult Services

Revised Date

FY 84

1.	POSITION TITLE: Social Worker III			RANGE/STEP: 16 A	BARG. UNIT: G.G.U.	FORM 12 PAGE/LINE	GOV.	APPROV.	D. APP.
2.	TYPE OF POSITION: PPT	STAFF MONTHS: 6	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION: Bethel	ELECTION DISTRICT	LEG.		

3.	CONTINUATION LEVEL		ADDITION	
4.	TYPE OF EXPENDITURE			AMOUNT
	1		2	3
	PERSONAL SERVICES			
5.	Salary		20,364	
6.	Benefits		1,248	
7.	Supplemental Benefits		3,440	
8.	Fixed Benefits		2,880	
9.	TOTAL PERSONAL SERVICES	01		27,972
10.	Travel	02		1,000
11.	Contractual	03		1,482
12.	Commodities	04		200
13.	Equipment	05		860
14.	Other			
15.	TOTAL COST			31,514

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		G.F. Match	1003	
18.		General Funds	1004	31,514
19.		I-A Receipts	1005	
20.		Program Receipts	1026	
21.		Other		

FOR BRU USE ONLY

AA KEY NUMBER ___ ___ - ___ ___ - ___ ___ - ___ ___ - ___ ___

JUSTIFICATION

This position will be necessary to provide information and referral, case assessment, case planning, authorizing and arranging for the placement of elderly in a residential care facility or adult foster home. It will also be responsible for assuming a portion of the current adult protective services caseloads which are in excess of the 50 cases per worker recommended on the national level.

13 REQUEST FOR NEW POSITION

AGENCY Health and Social Services

PROGRAM Social and Economic Assistance for the General Population

BRU Program Services

COMPONENT Adult Services

Revised Date

FY 84

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE CS FOR SENTATE BILL 122 (HESS)
PAGE 1

"An Act relating to protection of the elderly."

OVERVIEW

This Bill includes provisions for mandatory reporting of cases of physical and economic harm to elderly persons age 65 and over, investigation of reports of harm by the Department of Health and Social Services, and the offering of appropriate protective services to elderly persons in an effort to prevent or alleviate economic and physical harm. In addition to charging the Department with the duty to investigate reports of harm, the Department will have the following additional responsibilities if this Bill is passed.

1. Section 47.24.020(b) mandates the Department to provide to the Department of Law a copy of each report of an investigation of harm to an elderly person if the report of harm is confirmed to be true;

2. Section 47.24.070 authorizes the implementation of regulations to be approved by the Older Alaskans Commission before adoption by the Department; and

3. Section 47.24.075 mandates that the Department submit to the Older Alaskans Commission a quarterly statistical report of the Department's activities related to protection of the elderly.

STATEMENT OF THE PROBLEM

In the past few years there has been increasing awareness across the nation, including Alaska, of the problems of abuse, neglect, and exploitation of elderly persons who are unable to protect or care for themselves. In 1981 an Elder Abuse Task Force was created in Anchorage and a pilot project grant was awarded to the Anchorage Community Mental Health Clinic Geriatric Unit to address the issue of elder abuse. In 1982, Elder Abuse Task Forces were created in Fairbanks and Juneau.

Elderly Alaskans in need of protective services are served by the Division of Family and Youth Services under its Adult Protective Service program which serves adults age 18 and over who are not able to function independently or who may be subject to abuse, neglect, or exploitation. Adult Protective Services are provided on a voluntary basis by a mandate under Title XX of the Social Security Act and the general powers and duties of the Department to promote the health and well-being of Alaskans. Division social workers respond to voluntary reports of harm, investigate the circumstances of abuse, neglect, and exploitation, and

offer appropriate protective services. If an adult client does not consent to services and is not incapacitated as defined under AS 13.26.005, the guardianship statute, the Division has no legal authority to intervene. If, however, an investigation indicates that an adult is incapacitated, the Division may petition the court for a guardian.

As of June 15, 1983, the Division of Family and Youth Services Adult

Protective Service caseload was 1,056 clients, of whom 598 were age 65 and over. Of those clients age 65 and over, services to 372 clients or 62% were directed to the goal of preventing or remedying neglect, abuse or exploitation. The Division of Family and Youth Services Case Management Information System does not currently separate out these categories.

Division of Family and Youth Services' staff have actively participated in the Elder Abuse Task Forces. As a part of the Division's Fiscal Year 1983 Adult Protective Services Training Program, the issues of elder abuse, guardianship and conservatorship have been addressed. Community agencies, including programs serving older Alaskans, were invited and participated in these sessions which were conducted in Anchorage, Bethel, Fairbanks, Juneau, Ketchikan, and Nome.

Since reporting of harm to elderly persons is not mandatory, not all known cases are reported to a single agency. As a result, the actual extent of the problem is not known. However, we anticipate that mandatory reporting of physical and economic harm will result in increased caseloads. Social worker caseloads are such that additional staff will be necessary to meet the intent of this Bill. Furthermore, should the number of cases reported under the mandatory requirement significantly impact caseloads more than is anticipated, the Division will include necessary documentation to support the need for additional and staff, and travel and service dollars in the FY 85 budget. If additional staff, travel and service dollars become necessary but not available, the Division may not be able to meet the intent of the legislation.

RECOMMENDATION

The Department strongly endorses efforts to promote the independence and well-being of those elderly persons in need of protection. The procedures outlined in the Bill for action on reports, provision of protective services, review and referral, and confidentiality are in accordance with procedures established by the Department of Health and Social Services.

RECOMMENDED: Michael L Price
Michael L. Price, Director
Division of Family and
Youth Services

DATE: 6/17/83

APPROVED BY: Robert London Smith
Robert London Smith, Ph.D.
Commissioner

DATE: 6/24/83

SENATE [illegible] COMMITTEE OBSERVER/WITNESS SIGN-UP SHEET

DATE: 3/4/83 SPONSOR: Josephson

SUBJECT(S): SB 122 - Protection of the Elderly

NAME	REPRESENTING	ADDRESS	PHONE	Observer	Witness		
Barbara McPherson	Older Ak Commn	Juneau	465-3250		✓		
Howe M Kull	Older Ak Commn	"	586-2670		✓		
Michael Pinn	DPYS	"	465-2100				
Elizabeth Nelson	Senate Advisory	"	465-3114	✓			
Betty Bishop	Southeast Sr Services	"	586-6233		✓		
Margot Dick	Juneau Elder Abuse Task Force	"	" "		✓		
Jon B. Wolfe	Older Alaskans Com	"	465-3250	✓			
Dennis DeWitt	Hosp Assoc	"	586-1790		—		

SENATE HCD COMMITTEE OBSERVER/WITNESS SIGN-UP SHEET

DATE: 3/17/83 SPONSOR: HESS Committee

SUBJECT(S): CS SB 122 (HESS) ELDERLY PROTECTION

NAME	REPRESENTING	ADDRESS	PHONE	Observer	Witness		
DENNIS DeWITT	AK. ST. Hospital Assoc	319 SEWARD	586-1750		X		
ELIZABETH MUKTARIAN	DHSS	POUCH H05	465-3208		X		
Margaret Dick	SE Senior Services	419 6th St CCS Wing	586-6233		X		
Eileen Rehwaldt	OAC		465-3250		X		
Elizabeth Shaw	Dept of Law						

MEMORANDUM

TO: Senator Vic Fischer
FROM: John Hartle and Nan Groszek
RE: FY 84 Operating Budget Requests
DATE: 9 April 1983 (revised)

Program	needed	Gov	Gov AM	Page 4/8	Description
Community and Regional Affairs					
1. Displaced Homemakers Program	--	635.2	635.2	DCRA pg 31	Fund 8 grant programs statewide
2. CETA Youth Programs	--	0.0	1500.0	DCRA pg 20	Jobs for 1050 additional youth statewide
3. Child Assistance Programs	1250.3	7725.0	7725.0	DCRA pg 12	
Day Care assistance	901.5				Raise monthly grant from $265 to $300
Day Care Grants	196.8				Raise monthly grant from $21.25 to $25.00
Head Start Grants	152.0				Fully fund program
4. CETA	--	0.0	150.0	DCRA pg 17	State match for JTPA
5. Office of the Commissioner	495.0	362.6	662.6	DCRA pg 74	Fully fund ALSC (now have 300.0 in Gov AM)
Department of Revenue					
6. Child Support Enforcement (Gen. funds 112.6)	219.0	1023.2	1023.2	DREV pg 42	Add 1 new team (7 pos.) Foegie recommends.
Department of Administration					
7. Aging Grants	1649.2	1976.5	1976.5	DAdmin pg 30	Fed Funds Shortfall/Health services for senior centers

300 Hum Ser N.W.

225 Juneau
698 aging grants

1.1 million
add on???

800,000 rural areas

Program	needed	Gov	Gov AM	Page 4/8	Description
8. Public Defender Agency	139.4	2083.1	2083.1	DAdmin pg 38	1 Atty Palmer; 1 Legal sec'y Palmer; 1 Investigator Anch Fergie recommends
Department of Public Safety					
9. Council on Domestic Violence	947.0	4136.1	4136.1	DPS pg 83	Add to grants line; full funding 21 programs
Department of Health & Social Services					
10. Permanent Fund Hold Harmless ← retain to Permfund Bdg-Upd pg.	5000.0 (?)	--	--	DHSS pg 18	Assumes no repeal & $350 PFD
11. Infant Learning Program	500.0	1249.0	1294.5	DHSS pg 148	Add to grants line; Add 4 programs to serve 22 communities/additional disabled children
12. Pgm Svcs - Preventive Svcs - Child Abuse & Neglect Prevention	300.0	1439.1	1439.1	DHSS pg 50	Add to grants line; ~~COLA~~ & 4 new progrms statewide
13. Family Services Administration Southcentral Region	266.4	3219.1	3219.1	DHSS pg 58	4 SW III ANCH; 1 SW III Dillingham; 1 SSA I to SW I Seward; 1 SW II PT-FT Kenai
Northern Region	154.3	1641.9	1641.9	DHSS pg 60	2 SW III Fbks; 1 SW III Delta
Southeastern Region	47.1	561.7	561.7	DHSS pg 62	1 SW III Sitka
14. Homemaker Program	106.8	230.3	230.3	DHSS pg 46	Add to grants line; add ~~660~~ 7000 hours in-home preventention & intervention for child abuse & neglect
15. Youth Correctional Services 2nd & 4th Judicial Districts	130.0	907.6	907.6	DHSS pg 394	1 P.O. III Kotz; 1 P.O. III Bethel
3rd Judicial District	96.6	1164.2	1164.2	DHSS pg 392	Reduce vacancy & turnover factor
1st Judicial District	64.1	527.1	527.1	DHSS pg 390	Reduce vacancy & turnover factor

Do in table
minus 4 positions
not signed off on

Program	needed	Gov	Gov AM	Page 4/8	Description
16. Public Health - Field Nursing	333.0	4919.5	4995.9	DHSS pg 112	Reduce vacancy & turnover factor
17. Community Developmental Disabilities	195.7	4636.3	4714.1	DHSS pg 249	Add to grants line; ~~GOLS~~/ develop 1 sheltered workshop/respite programs
18. Community Mental Health Grants	82.2	4196.5	5501.2	DHSS pg 238	Add to grants line; ~~GOLS~~
19. Mental Health Admin. & Support	20.9	109.0	109.0	DHSS pg 260	Add to grants line; Continue AK Mental Health Assn. funding
20. Child & Family Health - Communicative Disorders	115.0	598.7	598.7	DHSS pg 140	1 Audiologist Nome/Kotz; 1 Sec'y Anch; 1 Program Service aide Mt Edgecomb
21. Youth Corrections - Fairbanks	~~45.2~~	~~1379.8~~	~~1379.8~~	DHSS pg 398	Reduce vacancy & turnover factor
Anchorage	~~100.0~~	~~6062.7~~	~~6168.6~~	DHSS pg 396	Reduce vacancy & turnover factor
22. GNM Catastrophic Illness	~~5540.0~~	~~2359.9~~	~~4659.8~~	DHSS pg 196	Fund pending claims
Department of Education					
24. Vocational Rehabilitation - Independant Living Rehab.	~~125.0~~ ~~148.0~~	187.0	187.0	DOE pg ~~120~~ 121	Fund Independant Options Now

D5122

Americans keeping on the move

Nearly half of citizens moved within five years

WASHINGTON (AP) — Living up to America's reputation as a mobile society, nearly half the U.S. population changed homes between 1975 and 1980, the Census Bureau reported Tuesday.

The moves accelerated the population shift from the North to the Sunbelt, as more than 3 million people moved to the South and West in that period.

Of 210 million Americans aged 5 and older, 94 million or 44.5 percent moved to a new house or apartment during the five years ended in 1980, the bureau said.

While many of those moved within the same state or county, there was a net shift of 3,164,620 Americans who left the Northeast or North Central states for new homes in the South and West.

"I would expect it (migration to the Sunbelt) to continue, I haven't seen any signs it would stop," said Kristin Hansen of the bureau's migration statistics staff.

The movement between 1975 and 1980 follows North-to-Sunbelt migration of 2.6 million Americans between 1970 and 1975, and of 1.3 million in the five years before that.

Alaska had the largest share of residents — 64.5 percent — who had moved there between 1975 and 1980, the bureau said. Nevada and Wyoming also reported large percentages of newcomers.

The state with the most arrivals was Florida, which gained 823,227 people during the five years. Texas added 574,007 and Washington gained 280,417.

New York was the largest loser of people among states, with a net migration decline of 1,097,197 for the five years. Illinois had the second highest

Enquirer 4-13-83

CSSB 122 (HESS) "An Act relating to the Protection of the elderly."

2-11-83 1st reading

3-21-83 HESS - Passes with CS
(Preliminary Fiscal Note attached)

The intent of this measure is to require persons in their professional duties, as well as any persons in a non-perfessional capacity, to report to the State Department of Health & Social Services any physical harm inflected on an elderly person.

Testimony has been given in support of this bill in the HESS Committee by the following:

1) Older Alaskans Commission
2) Division of Family & Youth Services
3) Southeast Senior Services
4) Alaska State Hospital Association

3-30-83 Position Paper/Department of Health & Social Services is attached with a revised fiscal note dated 3-23-83.

STANDING COMMITTEE REPORTS

SB 85

The Health, Education and Social Services Committee considered SENATE BILL NO. 85 (repealing the certificate of need program) and a majority of the committee recommended it be replaced with CS FOR SENATE BILL NO. 85 (HESS), entitled:

> "An Act suspending the certificate of need program; amending provisions related to assistance for health facility construction, Medicaid and general relief medical assistance; and providing for an effective date."

and do pass. The report was signed by Senator Josephson, Chairman and concurred in by Senators Halford, Paul Fischer and Moss.

SENATE BILL NO. 85 was referred to the Community and Regional Affairs Committee.

SB 122

The Health, Education and Social Services Committee considered SENATE BILL NO. 122 (protection of the elderly) and a majority of the committee recommended it be replaced with CS FOR SENATE BILL NO. 122 (HESS) and do pass. The report was signed by Senator Josephson, Chairman and concurred in by Senators Halford and Moss.

The committee further attached a preliminary statement of fiscal impact which appears in Senate Supplement No. 9 to today's journal.

SENATE BILL NO. 122 was referred to the Finance Committee.

SB 116

The Rules Committee considered SENATE BILL NO. 116 (placing emergency guards employed by the department of public safety in the exempt service) and a majority of the committee recommended it be placed on the March 21 calendar and adoption of the State Affairs Committee Substitute. The report was signed by Senator Faiks, Chairman and concurred in by Senators Kelly and Ferguson. Senator Bennett signed "no recommendation".

SENATE BILL NO. 116 appears on today's calendar.

SENATE
JOURNAL SUPPLEMENT

No. 9 3/21/83

SB
122

STATE OF ALASKA
PRELIMINARY STATEMENT OF FISCAL IMPACT

Bill No: Senate Bill No. 122 Date on Bill: February 11, 1983
Title: "An Act relating to protection of the elderly."

Sponsor: Josephson and V. Fischer
Requestor:

1. Estimated fiscal impacts on:

   a. Expenditures:

(Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86			
Capital							
Operating		17.5	19.3	21.2			
Total		17.5	19.3	21.2			

   b. Revenues:

Revenue							

2. Source of funds to offset fiscal impact of bill:

   The funding source was not identified by the authors of the Bill.

3. Assumptions:

   Passage of this Bill in its present form would necessitate educating the public through the news media and handouts. Regulations would need to be promulgated. These functions would be performed by existing staff. Without historical data for reporting abuse, neglect, or abandonment, the assumption is made that one-half again as many situations reported would result in placement, and counseling with both the individual and family.

4. Disclaimer:

   This statement has not been reviewed by the OMB in the Office of the Governor. It does not represent the policy of the Sheffield Administration or the final estimate of fiscal impact.

Prepared By: Michael L O'Brien Phone: 465-3170
Division: Family and Youth Services Date:

Approved by Commissioner: Robert Hamilton Bennett Date: 3/4/83
Department: Health and Social Services

1

CS FOR SENATE BILL 122 (HESS)

CHANGES:

Page 2, line 2	deleted "or employee"
Page 2, line 6	added "a village public safety officer" (did not include language recommended by the SE Senior Citizen's Task Force because that definition did not address VPSO's but did address federal officers)
Page 2, line 12	Added (12) a participant in the department's homemaker program or home health aide program.
Page 3, lines 4-5	Added "or a village public safety officer"
Page 3, lines 17-20	Deleted "make a reasonable effort" and added ", unless the person is incompetent, unconscious or otherwise physically unable to respond to questions."
Page 3, lines 26-28	Added "The department shall provide to the Department of Law a copy of each report of an investigation of harm to an elderly person that resulted from abuse."
Page 5	Delated Sec. 47.24.075. Evidence not priveledged. relating to the physician/patient and husband/ wife relationship.
Page 5, line 28	the word "willful" was not inserted before the word deprivation because legal counsel advised that that would require the burden of proof on the person reporting the suspected abuse.

Hein
3/16/83

Original sponsors: Josephson and V.Fischer

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 122 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to protection of the elderly."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. PURPOSE. In order to protect elderly persons from physical harm resulting from abuse, neglect, and abandonment and to assist elderly persons who are unable to protect or care for themselves, the legislature requires the reporting to the state by health professionals and others of cases involving elderly persons who have been or are being physically harmed. It is the intent of the legislature that these reports of harm be investigated and that appropriate protective services be offered in an effort to prevent or alleviate physical harm to the elderly persons of the state. It is further the intent of the legislature to provide immunity from civil or criminal liability to persons making good faith reports of physical or other harm to an elderly person.

* Sec. 2. AS 47 is amended by adding a new chapter to read:

CHAPTER 24. PROTECTION OF THE ELDERLY.

Sec. 47.24.010. REPORTS OF HARM. (a) The following persons who, in the performance of their professional duties, have reasonable cause to believe that an elderly person has suffered physical harm as a result of abuse, neglect, or abandonment shall, not later than 24 hours after first having cause for the belief, report the harm to the Department of Health and Social Services:

(1) a physician or other licensed health care provider;

(2) a mental health professional as defined in AS 47.30.-915(11);

(3) a pharmacist;

(4) an administrator of a nursing home, residential care or health care facility;

(5) a guardian or conservator;

(6) a police officer as defined in AS 18.65.290(2);

(7) a village public safety officer;

(8) a village health aide;

(9) a social worker;

(10) a member of the clergy;

(11) a staff employee of a project funded by the Older Alaskans Commission;

(12) a ~~participant in the department~~ an employee of a's homemaker program or home health aide program.

(b) A report of harm made under this section may include the name and address of the person reporting the harm and shall include

(1) the name and address of the elderly person;

(2) information relating to the nature and extent of the abuse, neglect, or abandonment;

(3) other information that the person reporting the harm believes might be helpful in an investigation of the case or in providing protection for the elderly person.

(c) A person who fails to comply with this section is guilty of a violation as defined in AS 11.81.900(55).

(d) This section does not prohibit a person listed in (a) of this section from reporting cases of physical or other harm to an elderly person that have come to the person' attention in a non-professional capacity, nor does it prohibit any other person from reporting physical or other harm to an elderly person that the person has reasonable cause to believe is a result of abuse, neglect, or

abandonment.

(e) If immediate action is necessary to protect the elderly person from imminent physical harm, the person shall make the report of harm to a police officer as defined in AS 18.65.290(2) or a village public safety officer. The police officer or village public safety officer shall take immediate action to protect the elderly person and shall, at the earliest opportunity, notify the department.

(f) A person who, in good faith, makes a report of physical or other harm to an elderly person under this chapter, or who participates in judicial proceedings related to the submission of reports under this chapter, is immune from any civil or criminal liability that might otherwise be incurred or imposed.

Sec. 47.24.020. ACTION ON REPORTS. (a) Upon receiving a report of physical harm, the department shall promptly initiate an investigation to determine the physical condition of the elderly person named in the report and whether action or services are needed for the protection of the elderly person. The department shall personally interview the elderly person during the investigation, unless the person is ~~incompetent~~ or mentally impaired to such an extent as to be, unconscious, or otherwise physically unable to respond to questions.

(b) The department shall prepare a written report of the investigation, including findings, recommendations, and a determination of whether and what kind of protective services are to be offered to the elderly person. Upon request, the person who reported harm to the elderly person shall be notified of the status of the investigation. The department shall provide to the Department of Law a copy of each report of an investigation of harm to an elderly person that resulted from abuse.

(c) The department shall immediately terminate an investigation

under this section upon the request of an elderly person who is the subject of a report of harm. However, if the department has reasonable cause to believe that the elderly person is incapacitated, the department may petition the superior court under AS 13.26 for appointment of a guardian or temporary guardian for the elderly person for the purpose of obtaining consent to continue the investigation.

Sec. 47.24.030. PROTECTIVE SERVICES. (a) The department shall provide available protective services to a harmed elderly person if and to the extent to which the elderly person consents. If the department has reasonable cause to believe that the elderly person lacks the capacity to consent to receiving protective services, it may petition the superior court under AS 13.26 for appointment of a guardian or temporary guardian for the elderly person for the purpose of obtaining consent.

(b) If an elderly person who has consented to receiving protective services is prevented by a caretaker from receiving the services, the department may assist the elderly person to petition the superior court for an injunction restraining the caretaker from interfering with the provision of protective services to the elderly person.

Sec. 47.24.040. REVIEW AND REFERRAL. The department shall, not later than 90 days after initiating the provision of protective services to an elderly person, initiate a review of the case to determine whether continuation or modification of protective services that are being provided is warranted. The department shall reevaluate the case every 90 days thereafter until the case is closed.

Sec. 47.24.050. CONFIDENTIALITY OF REPORTS. (a) Investigation reports and reports of harm filed under this chapter are confidential and are not subject to public inspection and copying under AS 09.25.-110 - 09.25.125. However, in accordance with this chapter and

department regulations issued under this chapter, investigation reports may be used by appropriate governmental agencies inside and outside the state, in connection with investigations or judicial proceedings involving abuse, neglect, or abandonment of an elderly person.

(b) The department shall disclose a report of harm if the elderly person who is the subject of the report consents in writing. The department shall, upon request, disclose the number of verified reports of harm that occurred at an institution for care of the elderly, ⟨that is certified by the state⟩

Sec. 47.24.060. AUTHORITY OF THE DEPARTMENT. In performing its duties under this chapter, the department may, subject to the person's consent, initiate actions necessary to assure the health, safety and welfare of an elderly person, including the transfer of the elderly person from a nursing home, residential care or health care facility.

Sec. 47.24.070. REGULATIONS. Regulations to implement this chapter shall be approved by the Older Alaskans Commission (AS 44.21.200) before adoption by the department.

Sec. 47.24.075. QUARTERLY REPORT. The department shall submit to the Older Alaskans Commission each quarter a statistical report of the department's activities related to the protection of elderly persons in the state. The report may not disclose the identity of victims or perpetrators of the abuse, neglect, or abandonment.

Sec. 47.24.100. DEFINITIONS. In this chapter

(1) "abandonment" means ~~willful~~ desertion of an elderly person by a caretaker;

(2) "abuse" means the infliction of physical pain, injury, or mental anguish, or the deprivation by a caretaker of services that are necessary to maintain the physical and mental health of an elderly

person;

(3) "caretaker" means a person who is responsible for the care of an elderly person as a result of family relationship, or who has assumed responsibility for the care of an elderly person voluntarily, by contract, or by court order;

(4) "department" means the Department of Health and Social Services;

(5) "elderly person" means a resident of Alaska who is 60 years of age or older;

(6) "incapacitated" means a person's ability to receive and evaluate information or to communicate decisions is impaired for reasons other than minority to the extent that the person lacks the ability to obtain the essential requirements for physical health or safety without court-ordered assistance;

(7) "neglect" means the failure by the caretaker or an elderly person to provide services necessary to maintain the physical and mental health of the elderly person;

(8) "protective services" means services intended to prevent or alleviate harm resulting from abuse, neglect, exploitation, or abandonment.

alaska state hospital association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

March 28, 1983

The Honorable Vic Fischer
Senator
Pouch V
Juneau, Alaska 99811

Subject: Senate Bill 122

Dear Senator Fischer:

You ask for clarification of our request that non-licensed employees of nursing homes not be required as a matter of law, with penalty to report elderly abuse. Simply put, we do not believe any higher obligation of citizenry ought to attach to unlicensed employees of a nursing home than it would if that same person, a cook or janitor for example, worked elsewhere.

Section 010 requires persons listed in subsections 1-12 to report elderly abuse when "in the performance of their professional duties, have reasonable cause to believe that an elderly person has suffered physical harm as a result of abuse, neglect or abandonment." Under subsection (c) a violation as defined in AS 11.81.900(55) attaches to anyone listed in Section 010 who fails to make a required report. Further, we would point out that subsections (d) and (f) encourage and offer civil immunity to those not required to make reports to do so as a matter of good conscience and concern for an abused person.

We believe that an obligation under law ought to attach only to those most likely to be able to effectively judge abuse. In the institutional setting, we suggest that licensed physicians, licensed nurses, administrators and social workers are far better qualified to make clinical judgements than cooks and janitors. Is, for example, a decubitus ulcer elderly abuse, or is a specific drug regimen, psychotropic for example, behavior modification for the patient's benefit in a case of depression or to minimize the number of nursing hours required by limiting the patient's mobility. We believe that trained persons should be required by law to make these judgements.

March 28, 1983

Since medical, nursing and social worker staffs are a required part of a licensed nursing home, unlike board and care or other facilities, we believe that a mandatory obligation upon professionals is sufficient protection for the patient.

In considering a mandatory obligation attaching to non-licensed employees of a nursing home we believe that consideration should be given to the employee's rights as well. We believe that persons employed by nursing homes should be encouraged to report and protected when they do report. CSSB 122 does this without burdening these individuals with a legal penalty when the sophistication of the abuse might well surpass the person's training. The bill requires "performance of professional duties." We simply do not believe that all employees in a nursing home have "professional duties."

The Alaska State Hospital Association supports CSSB 122(HESS) and believes that in its present form it will greatly improve the detection and prevention of elderly abuse.

I hope this clears up any misunderstandings about the position or attitudes of this association on the subject of elderly abuse.

Sincerely,

Dennis L. DeWitt
President

DLD:hb

cc: Senator Joe Josephson
Lois Pillifant, Senior Citizen Ombudsman

STATE OF ALASKA
FISCAL NOTE

Revision Date , 1983

I. REQUEST

Bill/Resolution No.: CSSB 122
Title: "... Protection of the Eld -ly"
Sponsor: Senators Josephson and V. Fischer
Requestor:

II. FISCAL DETAIL

Agency Affected: Administration
Program Category Affected: Social/Economic
BRU, Program of Subprogram(s) Affected:
Older Alaskans Commission
- Assistance for the Age

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

III. SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

IV. ANALYSIS: Attach a separate page for any Analysis

Prepared By: Jon B. Wolfe, Executive Director Phone: 465-3250
Division: Older Alaskans Commission Date: 5/16/83

Approved by Commissioner: Lisa Rudd Date: 5/16/83
Department: Administration

Distribution:
Original to Legislative Finance
Copy to Office of Management and Budget (for Legislature introduced bills)
Copy to Department (for Governor introduced bills)
Copy to Sponsor

STATE OF ALASKA
OFFICE OF THE GOVERNOR
BILL ANALYSIS

Department	Sponsor (Principal)	Bill Number
Administration	Rep. Clocksin	HB 192

Department Position

The Older Alaskans Commission supports the enactment of elderly protection legislation and the mandatory reporting of physical abuse of elderly persons.

Division Director	Date	Commissioner	Date
Jon B. Wolfe	3/3/83		

GOVERNOR'S OFFICE USE

Comments:

☐ Position Noted — By — Date

SUMMARY

1. Related Bills (Similar or Conflicting)

SB 122 Sens. Josephson & Fischer

1. b) Other Agencies Affected by Bill

Division of Family and Youth Services, DHSS

2. a) Organizational Support for Bill

1. Anchorage Elder Abuse Task Force
2. Office of Senior Citizen Ombudsman
3. Alaska White House Conference Delegates

2. b) Organizational Opposition to Bill

Unknown

3. Program Effects of Bill

The responsibilities assigned to the Commission under this legislation are consistent with current responsibilities and functions and will not require additional staff or expenditures. Under AS 44.21.230 the Commission is authorized to make recommendations with respect to regulations for services that benefit older Alaskans and to receive reports from state agencies concerned with the conditions and needs of older Alaskans.

4. Fiscal Impact: ☒ None ☐ Fiscal Note Attached

5. Amendments Proposed:

Commission staff recommends that "willful" be inserted before "deprivation" under Definitions, Sec. 47.24.100, (2) line 23.

6. Comments:

This legislation is consistent with AS 44.21 and the legislative mandates of the Older Alaskans Commission which seek to ensure health and dignity for the State's elderly. Historically elder abuse is a hidden social problem but one that is encountered by Commission funded senior programs statewide. These programs and the Commission will welcome specific procedures and services for handling these critical problems.

LOCAL AND NATIONAL FINDINGS:

FAMILY VIOLENCE AS CRIME:

- one-third (1/3) of all female homicide victims in California were murdered by their husbands (FBI, 1971)
- one-fourth (1/4) of all murders in San Francisco involve legally married or co-habiting mates (SFPD, Homicide Bureau, 1974)
- over 50% of all assaults and 40% of all assaults with a deadly weapon in the Bay Area on February 14, 1981 were the direct result of family violence (S.F. Examiner)
- a Kansas City study found that in 85% of all family homicides, police had been called at least once previously and in 50% of the homicides, the police had been called to the home five or more times prior to the murder (1978)

SEVERITY OF ASSAULTS:

- the Emergency Room at S.F. General Hospital reports that they treat 150-200 acutely battered women each month
- 20% of all hospital emergency room visits by women (and 70% of all sexual assault cases) are attributed to wifebeating (McGrath, 1979)

IMPACT ON THE CHILDREN:

- 25% of all victims of domestic violence are beaten when they are pregnant (Dr. Richard Gelles, 1975)
- in one-half of spouse abusing families, the children are battered as well (Women's Educational Action League, 1979)
- sixty-three percent of boys, ages 11-20, who commit homicide murdered the man who was beating their mothers (Senate Hearings)

ABUSE OF THE ELDERLY:

- five hundred thousand to one million elderly are abused in this country every year
- the most severe cases of violence seen by the Family Violence Project have been assaults on the elderly

FAMILY VIOLENCE PROJECT
50 Ivy Street, Second Floor, San Francisco, California 94102
(415) 552-6554

Mar 4, 1983
SB 122 - Protect of Elderly

Joe, Peggy, Halford

Barbara McPherson - Older Alaskans Comm.
21 states mandatory reporting laws for elder abuse
1982 - 16 reports of abuse to Senior Ombudsman -

Norma Lundy - Anch. Senior Citizens.

Dave Kull - OAC

Mike Price - Dir., Family & Youth Services.
11 Postal workers exclusively for the elderly
Various supports

position paper?
fiscal note?

Beth Bishop SE Senior Services
services in 15 communities in SE for 10 yrs.

add to list
village Pub. Saf. Officer
Home health aides.

Dennis DeWitt - Alaska State Hosp. Assoc.

Wanda Dan - Elder Abuse Task Force - Juneau Sept. 1982
19 agencies in Juneau represented.