

CLINICAL CASE MANAGEMENT: A STRATEGY TO COORDINATE DETECTION, REPORTING, AND PROSECUTION OF ELDER ABUSE

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ABSTRACT

Despite civil and criminal sanctions, elder abuse is a prevalent, underreported, and underprosecuted event in the United States. Traditional reporting statutes and common law remedies have had minimal effect on the incidence of elder abuse. The epidemic nature of elder abuse is projected to increase exponentially as the elderly population increases disproportionately over the next several decades. The fragmented system of detecting, reporting, and prosecuting abuse across a wide range of medical and legal settings creates a poor structure to effectively assist abused elderly individuals to receive support and protection, to have his or her situation reported and investigated, and, if necessary, to bring the perpetrator to justice. Emergency rooms and other facilities where elders are present for care should be staffed by clinically trained, knowledgeable individuals who have familiarity interacting with patients and providers across settings of care, and who are prepared to detect and report abuse. Nursing case managers fill this role well because they are able to coordinate efforts among acute and long-term care facilities and can supply patients with legal and clinical information about elder abuse. In addition, they may support prosecution efforts. They are able to coordinate efforts lacking in the current system to effectively evaluate, report, and protect elders from incidents of abuse, and to arrange for relevant services for the patient. Through clinical and special training in elder abuse, nursing case managers can provide expert testimony and other support to prosecution efforts against the perpetrators of this most egregious crime.

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INTRODUCTION

Currently the elderly comprise the fastest growing segment of the population. People over the age of sixty-five constitute more than thirteen percent of the total United States population.¹ This figure is expected to increase to more than twenty percent by the year 2030.² One reason for the rapid increase is that the elderly population is living much longer than they have in the past.³ But aging invariably leads to problems with chronic illness, disability, and cognitive changes for a

¹ Cf. Christine V. Williams, *The Nursing Home Dilemma in America Today: The Suffering Must be Recognized and Eradicated*, 41 SANTA CLARA L. REV. 867, 870 (2002) (stating that in 1997 thirteen percent of the nation's population consisted of people sixty-five years of age and older).

² See *id.* at 870 (stating that government estimates put the population of sixty five years of age and older at twenty percent of the total population by the year 2030).

³ See *id.*

large proportion of the elderly, who may then become vulnerable to abuse and mistreatment. Unfortunately, current reports estimate that “between 1 and 2 million Americans age 65 or older have been injured, exploited, or mistreated by someone on whom they depended for care or protection.”⁴

Despite recent increased attention and recognition of this problem, the incidence of elder abuse continues to escalate.⁵ Preliminary data from the 2004 national survey of state Adult Protective Services programs show a 61% increase in the number of elder and vulnerable adult abuse reports since 2000.⁶ Although the increase in reported cases could indicate that more cases are being reported to authorities due to increased awareness of the problem, there remain a significant number of cases of abuse and mistreatment that are never reported to authorities. The National Elder Abuse Incidence study reports that of the more than 500,000 victims of domestic abuse in 1996, only 16 percent of abusive situations were reported to authorities.⁷ The primary explanation for underreporting is that, although elder abuse is prevalent, it continues to be hidden from society.⁸ Only a minuscule number of reported cases ever result in criminal prosecution or lead to civil litigation.⁹

In California, the incidence of elder abuse is similarly dismal. Adult Protective Services receives reports of more than 225,000 cases of elder and dependent adult abuse each year, and two-thirds of reported abusers are family members.¹⁰ Despite the large number of reported

⁴ ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 9 (Richard J. Bonnie & Robert B. Wallace eds., 2002), available at <http://books.nap.edu/catalog/10406.html>.

⁵ See *id.*

⁶ NATIONAL ADULT PROTECTIVE SERVICES ASS'N, WHITE HOUSE CONFERENCE ON AGING POST-EVENT SUMMARY REPORT 2 (2004), available at http://www.whcoa.gov/about/des_events_reports/WNAPSA%20WHCOA%20REPORT%2010-26-2004.pdf.

⁷ “The best national estimate is that a total of 551,011 elderly persons, aged 60 and over, experienced abuse, neglect, and/or self-neglect in domestic settings in 1996. Of this total, 115,110 (21 percent) were reported to and substantiated by APS agencies. From these figures it was concluded that almost four times as many new incidents of elder abuse, neglect, and/or self-neglect were underreported than those that were reported to and substantiated by APS agencies in 1996. The standard error suggests that nationwide as many as 787,027 elders or as few as 314,995 elders could have been abused, neglected, and/or self-neglecting in domestic settings in 1996.” NATIONAL CENTER ON ELDER ABUSE, THE NATIONAL ELDER ABUSE INCIDENCE STUDY (1998), available at http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/ABuseReport_Full.pdf.

⁸ See Seymour Moskowitz, *Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect*, 36 LOY. L.A. L. REV. 589, 592 (2003).

⁹ See Seymour Moskowitz, *Saving Granny From the Wolf: Elder Abuse and Neglect—The Legal Framework*, 31 CONN. L. REV. 77, 78 (1998).

¹⁰ CALIFORNIA ATT'Y GENERAL'S CRIME AND VIOLENCE PREVENTION CENTER, ELDER AND DEPENDENT ADULT ABUSE, available at <http://safestate.org/index-print.cfm?navid=11> (last visited Oct. 8, 2005). See generally CAL. WELF. & INST. CODE § 15610.23 (Supp. 2005) (defining a “dependent adult” as any state resident between the ages of 18 and 64 years who

cases, it is estimated that only one in five cases of elder abuse are actually reported to authorities.¹¹ Thus a large number of elder abuse victims suffer in silence. With the elderly population in California expected to grow twice as fast as the total U.S. population, particularly for those over the age of eighty, the expected occurrence of elder and dependent adult abuse may continue to escalate.¹² Therefore, California serves as a useful indicator of future events and demonstrates the national need to combat elder abuse.

After the abusive event has occurred, factors such as age, health, changes in cognitive abilities, and limited finances make it even more difficult for an elderly individual to fully recover from the abuse or mistreatment.¹³ Additionally, elderly abuse victims commonly suffer from some form of a preexisting cognitive and physical deficit. Nationally, six out of ten elder abuse victims experience some degree of confusion and more than three in four have difficulty caring for themselves.¹⁴

Although these risk factors are well-documented, and policy makers and health care providers have paid increased attention to elder mistreatment, there is a lack of interest on the part of researchers and agencies that provide research funding.¹⁵ As a result, "little is known about its characteristics, causes, or consequences or about effective means of prevention or management."¹⁶ The National Institute on Aging ("NIA") reported that there are fewer than 50 peer-reviewed studies appearing in the scientific literature, and that there are "no comprehensive population-based stud[ies] on the incidence and prevalence of elder abuse, nor are there common definitions of elders, abuse, neglect or exploitation."¹⁷ Although the federal government has recognized this substantial problem, funding to combat the problem remains low.¹⁸ "The total federal expend-

has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age, or any person between the ages of 18 and 64 years who is admitted as an outpatient to a 24-hour health facility); CAL. WELF. & INST. CODE § 15610.27 (Supp. 2005) (defining "elder" as any state resident 65 years of age or older).

¹¹ CALIFORNIA ATT'Y GENERAL'S CRIME AND VIOLENCE PREVENTION CENTER, *supra* note 10.

¹² See CALIFORNIA DEP'T OF AGING, STATISTICS AND DEMOGRAPHICS, available at <http://www.aging.state.ca.us/html/stats/demographics.html> (last visited Oct. 8, 2005).

¹³ Sande Buhuai & James Gilliam, Jr., *Honor Thy Mother and Father: Preventing Elder Abuse Through Education and Litigation*, 36 LOY. L.A. L. REV. 565, 566 (2003).

¹⁴ Charles Pratt, *Banks' Effectiveness at Reporting Financial Abuse of Elders: An Assessment and Recommendations for Improvements in California*, 40 CAL. W. L. REV. 195, 203 (2003).

¹⁵ See ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA, *supra* note 4, at 1.

¹⁶ See *id.* at 2.

¹⁷ NATIONAL ADULT PROTECTIVE SERVICES ASS'N, *supra* note 6, at 2.

¹⁸ See *id.*

itures directed to elder abuse . . . in 2004 amounted to less than 1% of federal funds spent on family violence.”¹⁹ However, there is directed federal legislation aimed at protecting the elderly. For example, Title XX of the Social Security Act of 1974 mandates that states provide adult protective services (“APS”) programs to safeguard non-institutionalized elders and dependent adults.²⁰ In response to this legislation, all states currently fund reporting and response systems for elder abuse.²¹ Nevertheless, funding for elder abuse response and interventions remains limited.

Despite the government’s gradual increase in focus on the problem of elder abuse, the incidence and prevalence of elder abuse is increasing. This trend may be due to the fact that elder abuse is a difficult problem to detect. Elder abuse often occurs in the privacy of the home setting against persons who have minimal contact with the community and the outside world, making it “among the most hidden of contemporary America’s problems.”²²

The hospital setting may be the only source of outside contact and support for elderly abused victims.²³ Health care professionals may be the only people who associate with the victims and thus have the opportunity to recognize and report signs of abuse.²⁴ In order to ensure that abuse is reported to the proper authorities for criminal prosecution, individuals who make the initial contact and have access to the victims must first be able to identify elder abuse. However, many providers do not provide adequate training in the detection of elder abuse and mistreatment to their employees, nor do they adequately train their employees to make the appropriate referrals to protective service agencies.²⁵ To compound the problem, the signs of abuse and mistreatment are difficult even for health care providers to identify and manage.²⁶ As a result, a substantial number of cases of elderly mistreatment are never reported to authorities. Only the more severe cases of physical abuse and neglect, where the signs of injuries are readily obvious, get reported.²⁷ Addition-

¹⁹ *Id.* at 1.

²⁰ See 42 U.S.C.A. § 1397 (2005).

²¹ Nina Santo, *Breaking the Silence: Strategies for Combating Elder Abuse in California*, 31 McGEORGE L. REV. 801, 811 (2000).

²² Moskowitz, *supra* note 9, at 79.

²³ Fay S. Kahan & Barbara E.C. Paris, *Why Elder Abuse Continues to Elude the Health Care System*, 70 MT. SINAI J. MED. 62, 62 (2003).

²⁴ *Id.*

²⁵ *Id.*

²⁶ See generally *id.* at 1 (calling for the ongoing education of health care providers in learning how to identify symptoms of elder abuse and for collaboration between social workers and physicians in managing cases of elder abuse).

²⁷ Diana Meeks-Sjostrom, *A Comparison of Three Measures of Elder Abuse*, 36 J. NURS. SCHOLARSHIP 247, 247 (2004).

ally, many providers are unfamiliar with the procedure for reporting abuse and find the documentation forms and procedures for reporting confusing and onerous.

While many health care providers are unable to detect the often subtle signs of elder abuse and others are not adequately trained on the types of reportable abuse and signs and symptoms of elder abuse, certain health care professionals are in a better position to not only recognize and report elder abuse, but also to provide the appropriate services to protect victims. Specifically, an experienced case manager would be the primary individual within the health care setting to recognize and evaluate a patient for signs and symptoms of abuse, and provide support services and a safe environment for abused victims. Case management has been identified and recognized by many as an effective strategy to improve the quality of care for the aging population,²⁸ making the trained case manager the ideal individual to intervene on behalf of abused victims. Additionally, because victims rarely seek protection from abuse and will often react with denial, resignation, and passive acceptance,²⁹ initially recognizing that abuse has occurred and providing proper follow-up assistance is crucial to combating elder abuse. The case manager who is positioned in the health care setting, trained in elder abuse detection and reporting, and knowledgeable about referral to appropriate providers and agencies is in the best position to make a significant impact on the prevention, care and treatment of abused victims and to assist in the prosecution of perpetrators.

This article will discuss the growing elder abuse and mistreatment problem. It will explore the current criminal and civil remedies for elder abuse in the institutional and residential settings and mandatory reporting requirements. Current criminal law aimed at deterring and penalizing elder abuse perpetrators, penal mandatory reporting statutes requiring providers to report reasonably suspected cases of abuse, and civil remedies encouraging attorneys to accept cases of elder abuse deal ineffectively with this significant, escalating, and often hidden problem for lack of key individuals to identify cases, protect victims, and collaborate with other disciplines to report abuse. The current legal mandates and remedies would be more effective if there were a well-trained, well-educated group of designated health care providers that had first contact with the victims of abuse—individuals who possessed the skills and knowledge not merely to assess and evaluate for potential victims and report sus-

²⁸ Arlene D. Luu & Bryan Liang, *Case Management: Lessons from Integrated Delivery to Promote Quality Care to Elderly*, 9 J. MED. & L. 257 (2005).

²⁹ Christina Matias, *Part Two: Domestic Violence: Elder Abuse as Domestic Violence in California*, 11 J. CONTEMP. LEGAL ISSUES 76, 79-80 (2000).

pected cases to authorities, but who could also intervene and advocate on behalf of the abused individuals.

Part I of the article will discuss the types of abuse and the settings in which elder abuse often takes place. Part II will discuss California's statutory response including both criminal and civil remedies, laws governing nursing homes, as well as the legal mandates requiring providers to report reasonably suspected cases of abuse. We use California as our paradigm state because it is projected to be one of the fastest growing in the nation, with an expected overall elderly population increase of 112 percent between 1990 to 2020.³⁰ With the rapidly increasing elderly population, California provides a good example of the elder abuse problem, the currently available remedies, and what remains to be done.³¹ Part III will address the problems with the existing system for responding to this escalating problem. Part IV will discuss the role of the case manager in responding to elder abuse, screening for and reporting suspected cases of abuse, educating others about the significance of the problem, and providing care and resources to the victims. Finally, we conclude that the current elder abuse solution can be better coordinated and less fragmented by making trained case managers integral to the entire process—from prevention to detection, reporting, and prosecution.

I. ELDER ABUSE AND MISTREATMENT

A. TYPES OF ELDER ABUSE AND MISTREATMENT

Although every state has legislation to protect the elderly from abuse and mistreatment, their varying definitions of abuse, neglect, and exploitation are one reason for the difficulty in determining the true extent of the problem of elder abuse and mistreatment.³² Despite these variations, there are four main types of elder mistreatment recognized by most states.³³ These types are physical abuse, psychological abuse, financial exploitation, and neglect.³⁴ Abusive conduct can include intentional or unintentional acts of commission or omission.³⁵

³⁰ CALIFORNIA DEP'T OF AGING, STATISTICS AND DEMOGRAPHICS, *available at* <http://www.aging.state.ca.us/html/stats/demographics.html> (last visited Oct. 8, 2005).

³¹ Moskowitz, *supra* note 8, at 595.

³² See generally LAWRENCE A. FROLIK & ALISON McCHRYSTAL BARNES, *ELDER LAW CASES AND MATERIALS* (2002) (stating that mistreatment is typically characterized as abuse or neglect, *compare* New York, NY CLS Soc Serv § 473 which defines separately physical abuse, sexual abuse, emotional abuse, active neglect, passive neglect and self neglect, with physical abuse defined as "the non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained").

³³ Moskowitz, *supra* note 8, at 597.

³⁴ *Id.* at 596.

³⁵ *Id.* at 597.

Physical abuse usually consists of some form of violent conduct that results in pain and physical injury to the elderly. Such abuse can include striking, sexual molestation, and physical or chemical restraint of an elder.³⁶

Psychological abuse is willful behavior that results in significant mental anguish to the elderly and may consist of threats to harm, to institutionalize, or to isolate the individual.³⁷ Victims of psychological abuse often exhibit signs of depression, nervous system disorders, fearfulness, physical illness, and suicidal tendencies.³⁸

Financial abuse is the unauthorized or exploitative use of funds, property or resources of an elderly person by his or her relatives, caregivers, or others.³⁹ Examples of financial abuse include expropriating small amounts of money or "inducing the elder to sign away bank accounts or other property."⁴⁰ It is often accompanied by physical or psychological abuse.⁴¹

Neglect is the willful or passive "failure to fulfill a care-taking obligation necessary to maintain the elder's physical and mental well-being."⁴² Neglect can consist of abandonment, isolation, and denial of food and health care services to the elderly.⁴³ Neglect can include intentional or negligent acts resulting from a caretaker's own frailty or lack of knowledge.⁴⁴ Self-neglect is self-directed conduct by an older person that threatens his or her safety or health⁴⁵ and can occur when the elderly person is unable to care for himself or herself but continues to attempt to live alone or when he or she is unwilling to accept help from family or health care providers.

B. ELDER ABUSE IN THE RESIDENTIAL SETTING

The most common victims of elder abuse are women, age seventy-five or older, who are dependent on the perpetrator for care and support.⁴⁶ The perpetrators are usually caregivers for the elderly and are frequently family members or nursing home employees.⁴⁷ In the residential setting, the largest categories of perpetrators in substantiated inci-

³⁶ *Id.*

³⁷ *Id.* at 597-98.

³⁸ *Id.* at 598.

³⁹ Moskowitz, *supra* note 9, at 91.

⁴⁰ Moskowitz, *supra* note 8, at 598.

⁴¹ *Id.* at 599.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.* at 599-600.

⁴⁵ Moskowitz, *supra* note 9, at 91.

⁴⁶ FROLIK & BARNES, *supra* note 32, at 636.

⁴⁷ *Id.* at 637.

dents of elder abuse are adult children and spouses.⁴⁸ The abuse may be characterized as physical, psychological or general neglect, but is usually not financial abuse.⁴⁹

Causative factors identified for abuse and neglect in the home environment include the financial and emotional strains of caring for the needs of a frail, dependent elderly individual.⁵⁰ Caregivers are often overwhelmed by having to provide for the daily care needs of an infirm person and by the economic hardships of providing such care.⁵¹ The unexpected presence of an elderly parent in the middle-aged child's home requires drastic changes in routines, budget, and lifestyle and can result in a gradual buildup of stress as the needs of the elderly parent increase.⁵² These economic, physical, and emotional strains brought on by caring for an elderly individual are the main reason that abuse occurs. Other precipitating factors leading to abuse include stress, substance abuse, a family history of violence, and the absence of support for the caregivers and the victims.⁵³

In California, the Domestic Violence Prevention Act ("DVPA") provides some protection from certain intentional or reckless types of physical abuse.⁵⁴ It primarily protects individuals from acts of assault and battery.⁵⁵ Domestic violence is abuse perpetrated against a spouse, former spouse, cohabitant, former cohabitant, or person with whom the suspect has a dating or engagement relationship.⁵⁶ Under the DVPA, abuse means "any intentional or reckless act to cause or attempt to cause bodily injury, sexual assault or . . . to place a person in reasonable apprehension of imminent serious bodily injury."⁵⁷

Although the statute does not specifically address the elderly, the DVPA's protection extends to elders who live with or are related to the perpetrator.⁵⁸ A mistreated elderly individual may obtain an emergency

⁴⁸ Moskowitz, *supra* note 8, at 645.

⁴⁹ *Id.*

⁵⁰ FROLIK & BARNES, *supra* note 32, at 639.

⁵¹ Santo, *supra* note 21, at 805.

⁵² Jill C. Skabronski, *Comment, Elder Abuse: Washington's Response to a Growing Epidemic*, 31 GONZ L. REV. 627, 632 (1995/1996).

⁵³ Santo, *supra* note 21, at 805.

⁵⁴ Matias, *supra* note 29, at 77. New Jersey's Prevention of Domestic Violence Act of 1991 also specifically recognizes abuse of the elderly by declaring in the Legislative history that "violence against the elderly and disabled, including criminal neglect of the elderly and disabled . . . must be recognized and addressed on an equal basis as violence against spouses and children in order to fulfill our responsibility as a society to protect those who are less able to protect themselves." See N.J. STAT. § 2C:25-17 (2005). The state of Washington has also passed similar laws. See Rev. Code Wash. (ARCW) § 10.99.010 (2005).

⁵⁵ Matias, *supra* note 29, at 77.

⁵⁶ See CAL. FAM. CODE § 6211 (2003).

⁵⁷ CAL. FAM. CODE § 6203 (2003).

⁵⁸ *Id.*

or regular order of protection if there is an "immediate and present danger of domestic violence."⁵⁹ Law enforcement officials can also obtain an emergency protective order if they have reasonable grounds to believe an individual is in danger of immediate abuse.⁶⁰ The problem with this remedy is that most existing domestic violence programs and shelters have difficulty or are unable to provide for the special needs of the elderly.⁶¹ Moreover, invoking the DVPA's protection usually results in removal of the abuser or the elder from the home, possibly leading to problems with care, alternative living arrangements, and financial hardship for the elder.⁶² These factors limit the scope and application of the DVPA's protection for abused elders.⁶³

C. ELDER ABUSE IN THE INSTITUTIONAL SETTING

A large number of the elderly reside in nursing homes operated by for-profit corporations.⁶⁴ It is estimated that more than 1.7 million Americans reside in nursing homes throughout the United States.⁶⁵ Approximately 43 percent of all persons 65 years of age will use a nursing home at some time in their lives.⁶⁶ In California, approximately 220,000 residents received care in 1,800 skilled nursing facilities in 1999.⁶⁷

Residents in nursing homes are a highly vulnerable population, often with multiple physical and cognitive impairments,⁶⁸ and due to their high level of disability and multiple chronic conditions, residents generally require extensive assistance with their care needs.⁶⁹ Despite the fact that the quality of the care in nursing homes is the subject of extensive state and federal regulation and enforcement, as well as private civil litigation, the effectiveness of administrative enforcement has been

⁵⁹ Moskowitz, *supra* note 8, at 646.

⁶⁰ *Id.*

⁶¹ *Id.* at 647.

⁶² Matias, *supra* note 29, at 78.

⁶³ *Id.*

⁶⁴ Daniel N. Gitner, *Nursing the Problem: Responding to Patient Abuse in New York State*, 28 COLUM. J.L. & SOC. PROBS. 559, 564 (1995). Nursing homes "provide nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health care services These facilities provide patients with long-term treatment and care in a home setting. Nursing home patients are usually elderly and depend on others for their care and well-being. They often require assistance carrying out basic activities such as dressing, bathing, and toileting provided for by nurse aides Nursing home patients also require continuing medical care, which doctors and nurses provide." *Id.*

⁶⁵ Moskowitz, *supra* note 8, at 623.

⁶⁶ CALIFORNIA ATT'Y GENERAL'S CRIME AND VIOLENCE PREVENTION CENTER, PREVENTING CRIME AND VIOLENCE IN CALIFORNIA, available at <http://safestate.org/index-print.cfm?navid=11> (last visited Oct. 8, 2005).

⁶⁷ *Id.*

⁶⁸ Moskowitz, *supra* note 8, at 594.

⁶⁹ *Id.*

questioned.⁷⁰ Regulations customarily enforced by state agencies are aimed at improving the quality of care rendered at nursing homes,⁷¹ but these government standards do not guarantee nursing home residents adequate service and care.⁷² Due to their age and vulnerability, many nursing home patients are more susceptible to abuse in these settings.⁷³

Although abuse allegations are usually made against nurse aides who provide direct care to residents, any person—including nurses, doctors, and other providers in the nursing facility can commit abuse.⁷⁴ Abuse often involves acts that cause pain or injury to the residents⁷⁵ and can involve forcible acts, such as grabbing, striking, or slapping an elderly patient, or neglecting to care for patients.⁷⁶ Allegations of abuse usually fall into certain categories: deaths of patients under suspicious circumstances or situations indicating deficient care; assaults, including sexual abuse; violent treatment; unexplained physical injuries; facility conditions or staff neglect that endangers patients' health and safety; and reckless treatment of patients.⁷⁷

A number of factors have been attributed to abuse in the nursing home setting.⁷⁸ Nursing homes are often under-financed, which results in under-staffing, low wages, high turnover rates and a lack of resources.⁷⁹ Poor-quality working conditions can precipitate stress and frustration among staff, which may result in resident abuse.⁸⁰ Additionally, "nursing home staff are often inadequately trained to deal with the physical, emotional, and psychological aspects of caring for the elderly. Inadequate training may result in abuse as an improper response to a stressful or confrontational situation."⁸¹ Moreover, even though every state is required to maintain a nurse aide registry that includes information regarding the aide's past charges of abuse, there is no national nurse's aide registry.⁸² As a result, those aides found abusing patients in one state can often quickly and easily find work in another⁸³ because of the high demand for nurse aides.

⁷⁰ *Id.*

⁷¹ See Gitner, *supra* note 64, at 565. While his article focuses on New York State's legal responses to nursing home patient abuse regulation, Gitner expressed that the issues discussed apply generally to cases of patient abuse. See *id.* at 561.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.* at 567.

⁷⁵ *Id.* at 561.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 567.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.* at 568.

⁸³ *Id.*

Not unlike the home setting, discovering cases of elder abuse in nursing homes can often be difficult. Nursing home patients generally receive few visitors, are isolated from society, and many lack the physical and mental capacity to complain.⁸⁴ Patients in nursing care facilities and their families are also reluctant to report abuse for fear of retaliation by staff members, and residents may not possess the mental alertness to report or provide accurate accounts of events.⁸⁵ Although a willful failure to report patient abuse is prohibited, nursing home employees are often reluctant to report their colleagues for committing acts of abuse.⁸⁶ Yet, the detection and proof of abuse are difficult without the cooperation of nursing home staff and other health care professionals.⁸⁷

D. PROBLEMS IN PROSECUTION

In addition to the difficulties of detecting abuse in the institutional setting, bringing abuse cases to trial in both the criminal and civil contexts can also be difficult.⁸⁸ Abuse victims are often physically frail, and may become ill or die before the adjudicative process is complete.⁸⁹ Similarly, patients who were not mentally alert at the time of an incident or at trial may be unable to provide accurate information and are vulnerable on cross-examination.⁹⁰ Merely bringing an elderly patient to court may pose a challenge because the individual may need to have an aide to help with care needs or may be too frail to sit through the court proceedings.⁹¹ But because acts of abuse often occur behind closed doors, a victim's testimony is often crucial in order to convict the perpetrator.⁹² When the victim is unable to testify, the abuser can more easily present himself or herself as a party victimized by the prosecution.⁹³ In the criminal context, the guilt standard of "proof beyond a reasonable doubt" can greatly increase the difficulty in presenting a patient abuse case.⁹⁴

⁸⁴ *Id.*

⁸⁵ *Id.* at 569.

⁸⁶ *Id.* at 570.

⁸⁷ *Id.* at 569.

⁸⁸ *Id.* at 570.

⁸⁹ *Id.* at 571-71.

⁹⁰ *Id.* at 571.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

II. EXISTING EFFORTS TO PROTECT THE ELDERLY FROM ABUSE

A. OVERVIEW

The current criminal and civil law and remedies were enacted to protect victims of abuse, whether in the residential or institutional setting. Federal hearings in the 1980s began to expose the problem of elder abuse by demonstrating that the traditional civil and criminal remedies were inadequate responses to the growing elder abuse problem.⁹⁵ In response, many states created abuse response services or adult protective service systems ("APS") to fulfill their obligation to provide for the health and welfare of the elderly population.⁹⁶ The APS departments in each state function to prevent abuse and neglect of the vulnerable population and to provide supportive services either in the home or, if necessary, to remove the vulnerable person to a safe location.⁹⁷ Although APS programs vary by state, most procedures for investigations provide for various interventions on behalf of the elderly individual, and require mandatory reporting of suspected abuse by specified professionals.⁹⁸

B. THE ELDER ABUSE AND DEPENDENT ADULT CIVIL PROTECTION ACT

In California, the Elder Abuse and Dependent Adult Civil Protection Act ("EADACPA") was enacted in 1991 to protect vulnerable elderly and dependent adults.⁹⁹ The statute declares infirm elderly persons and dependent adults to be disadvantaged class and explicitly recognizes the state's duty to protect these individuals.¹⁰⁰

Further, EADACPA declares that because cases of abuse are seldom prosecuted or accepted due to problems of proof, delays and the lack of incentives, the goal of the statute is to encourage private attorneys to represent victims, make litigation more economically feasible, and ensure that mandated reporters take necessary actions to protect the victims.¹⁰¹ The statute also defines elder abuse, establishes procedures for reporting of actual and suspected abuse, and sets out penalties for failure to report.¹⁰² Additionally, EADACPA sets out requirements for the

⁹⁵ FROLIK & BARNES, *supra* note 32, at 646.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ Moskowitz, *supra* note 8, at 600.

¹⁰⁰ See CAL. WELF. & INST. CODE § 15600 (1994).

¹⁰¹ See *id.* A Washington state statute enacted in 1995 encourages legal representation of the elderly by making attorney's fees and court costs recoverable and available in addition to other remedies available under Washington law. See WASH. REV. CODE § 74.34.200 (Supp. 1996).

¹⁰² See generally *id.*

training of mandated reporters, authorizes APS to conduct investigations and provide other services in response to the report, and allows for enhanced remedies when there is clear and convincing evidence of elder abuse.¹⁰³

To encourage private attorneys to accept cases involving elder abuse, EADACPA suits have no cap on non-economic damages, allow punitive damages, permit recovery for pain and suffering even after the victim dies, and grant attorney fees and costs.¹⁰⁴ For example, the statute "permits recovery of up to \$250,000 for pain, suffering, or disfigurement when the person with a cause of action for elder abuse dies before final judgment" and "requires courts to award attorney's fees and costs to successful plaintiffs."¹⁰⁵

Under the statute, abuse of an elder or dependent adult is broadly defined to encompass "[p]hysical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment that results in physical harm, pain or mental suffering."¹⁰⁶ It can also consist of the "deprivation by a care custodian of goods or services that are necessary to avoid physical harm or suffering."¹⁰⁷

Care custodians include not only persons providing direct care or services but also administrators and support staff in a variety of settings such as clinics, camps, and twenty-four hour health facilities.¹⁰⁸ "Goods and services necessary to avoid physical harm or mental suffering" could include medical care, hygiene assistance, adequate clothing, shelter, protection from malnutrition and transportation necessary to secure any of those needs.¹⁰⁹

C. CRIMINAL ELDER ABUSE

Although, due to their age, the elderly are viewed as particularly vulnerable to violent crime, the reality is that violent crimes such as murder, rape, kidnapping, and assault are far less commonly committed against persons over age 65.¹¹⁰ The elderly are more susceptible to crimes motivated by financial gain such as robbery, intimidation, vandalism, forgery, fraud, burglary and automobile theft.¹¹¹

¹⁰³ Santo, *supra* note 21, at 822.

¹⁰⁴ Moskowitz, *supra* note 8, at 606.

¹⁰⁵ Santo, *supra* note 21, at 822.

¹⁰⁶ See CAL. WELF. & INST. CODE § 15610.07 (1994).

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at § 15610.17.

¹⁰⁹ *Id.* at § 15610.35.

¹¹⁰ Moskowitz, *supra* note 8, at 632.

¹¹¹ *Id.*

Abuse and neglect are also crimes primarily committed against the elderly.¹¹² Although almost every form of elder mistreatment corresponds to some common law or statutory crime, most states have declared that violence against the elderly is not acceptable by specifically criminalizing elder mistreatment as separate crimes.¹¹³ Most states now recognize that the physical, financial and behavioral impacts of crime against the elderly—either by a caretaker or a stranger—are much greater than upon younger victims.¹¹⁴ Therefore abuse, neglect, and financial exploitation of the elderly have been made specific crimes in most jurisdictions.¹¹⁵ Additionally, “most states allow the advanced age of the victim to be considered as an aggravating factor in sentencing” while “others designate various crimes, including assault, battery, and robbery as more serious crimes when committed against an elderly person.”¹¹⁶

California Penal Code Section 368 has declared that crime against elders and dependent adults are “deserving of special consideration and protection.”¹¹⁷ Under Section 368(b), it is a felony for any persons under circumstances likely to produce great bodily harm or death to willfully cause or permit an elder or dependent adult to suffer, or to inflict upon the individual unjustifiable physical pain or mental suffering.¹¹⁸ It is also a felony for any person having the care or custody of an elder or dependent adult to willfully cause or permit the person to be injured or to be placed in a situation in which his or her health is endangered.¹¹⁹ The penalty for the violation of Section 368(b) is imprisonment in a county jail for up to one year or by a fine up to six thousand dollars, or both, or alternatively by imprisonment in a state prison up to a maximum of four years.¹²⁰

If in the commission of the offense, the victim suffers great bodily injury, the defendant will receive up to an additional five years in

¹¹² *Id.*

¹¹³ Moskowitz, *supra* note 9, at 98. *See, e.g.*, TENN. CODE ANN. § 71-6-117 (2004) (declaring it unlawful for any person to willfully abuse, neglect or exploit any adult within the meaning of the provisions); WYO. STAT. § 6-2-507 (2004).

¹¹⁴ Moskowitz, *supra*, note 8, at 634. *See, e.g.*, DEL. CODE ANN. TIT. 11, § 841 (2004) (imposing an augmented sentence if the victim is sixty-two years of age or older); NEV. REV. STAT. ANN. § 193.167(1)-(2) (2004) (imposing an augmented sentence if the victim is sixty years of age or older).

¹¹⁵ *Id.* at 633.

¹¹⁶ *Id.* at 633. *See, e.g.*, FLA. STAT. ANN. § 784.08(2) (2005) (declaring that when a person is charged with committing an assault or aggravated assault or battery upon a person sixty-five years of age or older, the offense shall be reclassified to a more serious offense).

¹¹⁷ CAL. PENAL CODE § 368(a) (2005).

¹¹⁸ *Id.* at § 368(b)(1).

¹¹⁹ *Id.*

¹²⁰ *Id.*

prison.¹²¹ In the event that the defendant is the proximate cause of the death of the victim, he or she will receive an additional term in prison of up to seven years.¹²² Under circumstances other than those likely to produce great bodily harm or death, the defendant is only guilty of a misdemeanor; a second violation will be punishable by a fine not exceeding two thousand dollars, or by imprisonment not exceeding one year or both.¹²³

Other aspects of the statute address theft, embezzlement, forgery, or fraud against an elderly or dependent adult.¹²⁴ Additional sections of the statute declare that it is a felony to falsely imprison an elder or dependent adult by violence, menace, fraud, or deceit; such crimes are punishable by imprisonment of up to four years.¹²⁵ However, the California Penal Code does not apply to individuals who do not owe a duty to the elderly person and even persons having knowledge of the abuse may not be under a duty to protect the elderly. In *People v. Heitzman*,¹²⁶ the California Supreme Court held that, although the statute does not define who has a duty to protect the elderly, only persons with a special relationship to the elderly individual would have a duty to act to prevent abuse.¹²⁷

California allows for an expedited trial when an elderly person is a witness or victim.¹²⁸ If the witness or victim is at least seventy years old or a dependent adult, the case is given precedence over other criminal trials and trial usually begins within thirty days unless the court finds that a continuance is necessary.¹²⁹

The California Attorney General's Office has declared that elder abuse is one of its top priorities.¹³⁰ In addition to guarding the state's Medi-Cal program from fraud and abuse, the Attorney General's Bureau

¹²¹ *Id.* at § 368(b)(2). Under CAL. PENAL CODE § 12022.7, great bodily injury is defined as significant or substantial physical injury.

¹²² *Id.* at § 368(b)(3).

¹²³ *Id.* at § 368(c).

¹²⁴ *Id.* at §§ 368(d)-368(e).

¹²⁵ *Id.* at § 368(f).

¹²⁶ 886 P.2d 1229 (Cal. 1994). In *Heitzman*, a daughter was charged with violating CAL. PENAL CODE § 368(a) for abuse of her elderly father. The California Supreme Court held that criminal liability under the statute was properly based, not on the relationship between the defendant and her father, but rather between defendant and the alleged abusers—her brothers. The trial court order of dismissal was proper because there was no evidence that defendant had a legal duty to control the conduct of either of her brothers. The court held that the statute could not impose criminal liability on defendant because she had no legal duty to control her brothers who were the caretakers and alleged abusers. *Id.*

¹²⁷ *Id.* at 1243-44.

¹²⁸ Moskowitz, *supra* note 8, at 643. Cf. COLO. REV. STAT. § 18-6.5-105 (2004).

¹²⁹ CAL. PENAL CODE § 1048(b)(c) (2005). In Colorado, all cases involving the commission of a crime against an at-risk adult shall take precedence and the court shall hear the case as soon as possible after they are filed. See COLO. REV. STAT. § 18-6.5-105 (2004).

¹³⁰ See OFFICE OF ATT'Y GEN., STATE OF CALIFORNIA DEP'T OF JUSTICE, available at <http://caag.state.ca.us/bmfea/press/03-001.htm>.

of Medi-Cal Fraud and Elder Abuse ("BMFEA") "also protect[s] patients in nursing homes and other long-term care facilities from abuse or neglect."¹³¹ "The BMFEA prosecutes individual employees and corporate entities . . . for committing physical abuse and engaging in policies and practices that lead to neglect and/or poor quality care."¹³² The Bureau "investigates and prosecutes abuse in the nearly ninety percent of California's long-term care facilities that receive Medi-Cal funding."¹³³

In addition to its investigative and prosecutorial functions, the Attorney General's Office has implemented other strategies to help combat the elder abuse problem in California. As part of a media campaign to increase recognition of elder abuse, the AG's Office created a hotline that directly connects individuals reporting abuse to their local APS agency or the Long-Term Care Ombudsman Crisis Line.¹³⁴ Additionally, the AG's office has mandated that all long-term care facilities "provide training to their staff in recognizing and reporting elder and dependent adult abuse."¹³⁵ Operation Guardian is a partnership program by the AG's Office and other state, local, and federal agencies to conduct unannounced visits to the state's 15,000 nursing homes to inspect for health and safety violations and to encourage facilities to provide quality care routinely—not just before an anticipated inspection.¹³⁶

D. CALIFORNIA'S CIVIL REMEDIES FOR ELDER ABUSE

Under EADACPA, lawyers are encouraged to take cases of elder abuse.¹³⁷ Previously, pain and suffering damages were unavailable if the patient died before the conclusion of litigation, causing attorneys to hesitate before accepting elder-abuse cases.¹³⁸ EADACPA now allows a decedent's family to claim pain and suffering damages of up to \$250,000.¹³⁹ "Punitive damages are also available if the plaintiff proves by clear and convincing evidence that the defendant fraudulently, maliciously, or oppressively disregarded the patient's care."¹⁴⁰ Additionally, EADACPA's enhanced remedy is not just available against perpetrators in the residential context and outside the provision of health care ser-

¹³¹ OFFICE OF ATT'Y GEN., STATE OF CALIFORNIA DEP'T OF JUSTICE, BUREAU OF MEDICAL FRAUD AND ELDER ABUSE, <http://ag.ca.gov/bmfea/index.htm>.

¹³² CALIFORNIA HEALTH ADVOCATES, THE CALIFORNIA HICAP ASS'N, <http://www.cahealthadvocates.org/newsletter/2004/10Bureau.html>.

¹³³ Santo, *supra* note 21, at 824.

¹³⁴ CALIFORNIA ATT'Y GENERAL'S CRIME AND VIOLENCE PREVENTION CENTER, PREVENTING CRIME AND VIOLENCE IN CALIFORNIA, <http://safestate.org/index-print.cfm?navid=11>.

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ Buhai and Gilliam, Jr., *supra* note 13, at 570.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 570-571.

vices.¹⁴¹ It is also available to victims of abuse and neglect perpetrated by health care providers who are guilty of something more than negligence.¹⁴² To prevail, the plaintiff must demonstrate that the defendant engaged in oppressive, fraudulent or malicious conduct, or reckless neglect.¹⁴³

In addition to the civil remedies, under EADACPA, victims and families can seek redress through the traditional tort system.¹⁴⁴ Some examples include battery claims for physical or sexual abuse, negligence suits for neglect situations, and fraud and conversion theories for misuse of funds.¹⁴⁵ Even traditional tort claims in California can be augmented under EADACPA if it is proven by clear and convincing evidence that the defendant is guilty of recklessness, oppression, fraud or malice in the commission of the abuse.¹⁴⁶

Even though victims can seek relief under the traditional tort system or EADACPA, there have been few cases employing civil tort or EADACPA remedies outside the institutional context.¹⁴⁷ Reasons for this lack of precedent could include: recovery is often difficult against perpetrators who have limited resources, elder abuse is usually hidden, abuse is rarely revealed to those outside the family environment, and victims often do not report because of the shame of admitting they have been abused.¹⁴⁸ Alternatively, the victim and abuser may be in a mutually dependent relationship in which the victim has no other source of support, fears institutionalization, feels powerless, lacks self-esteem, or fears social isolation.¹⁴⁹

E. PROTECTION FROM ABUSE IN NURSING HOMES

Nationally, about one percent of persons aged sixty-five to seventy-four years old, six percent of persons aged seventy-five to eighty-four years old, and twenty-four percent of people aged eighty-five and older reside in nursing homes.¹⁵⁰ These numbers will increase as the population continues to age.¹⁵¹ The federal government pays for a large proportion of all nursing home care through public programs, particularly Medicaid. Because of this funding, the federal government is also re-

¹⁴¹ Santo, *supra* note 21, at 828.

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ Moskowitz, *supra* note 8, at 605.

¹⁴⁵ *Id.* at 604-05.

¹⁴⁶ *Id.* at 605.

¹⁴⁷ *Id.* at 607.

¹⁴⁸ *Id.* at 607-08.

¹⁴⁹ *Id.* at 608.

¹⁵⁰ Williams, *supra* note 1, at 871-72.

¹⁵¹ *Id.* at 872

sponsible for conducting oversight reviews, evaluations, and audits.¹⁵² The Budget and Accounting Act of 1921 established the Government Accountability Office (previously known as the General Accounting Office; "GAO"), an investigative arm of Congress, to work with state licensing boards and statutes through its Health and Human Services Division to create comprehensive oversight programs on nursing homes.¹⁵³ In addition, the Health Care Financing Administration ("HFCA"), now the Centers for Medicare and Medicaid Services ("CMS"), was given enforcement authority over federally-funded facilities.¹⁵⁴ CMS and state officials ensure that nursing homes comply with their contracts with the states to conduct onsite inspections and meet minimum Medicare and Medicaid quality and performance standards.¹⁵⁵ Nursing homes in California are governed by the Long-Term Care, Health, Safety and Security Act of 1973 and by Title 22 of the California Code of Regulations.¹⁵⁶ Nursing Homes in any state receiving payments from Medicare or Medicaid must comply with both state and federal regulations.¹⁵⁷

Even though the quality of care in nursing homes is subject to extensive administrative state and federal regulations along with some private litigation, conditions in many nursing homes are still considered unacceptable.¹⁵⁸ The residential nature of nursing homes and high levels of disability and dependency for the population create great needs for care and assistance among the residents in institutional settings.¹⁵⁹ A 2003 GAO report found that a large fraction of nursing homes have serious quality problems, despite a reduction in the incidence of reported problems.¹⁶⁰ Serious regulatory problems that caused actual harm or placed residents in immediate jeopardy were noted by the report in 20 percent of nursing homes across the nation.¹⁶¹ The GAO report also found that state surveyor confusion regarding the definition of harm, in-

¹⁵² *Id.* at 875.

¹⁵³ *Id.* at 876.

¹⁵⁴ *Id.* The Department of Health and Human Services oversees the Medicare and Medicaid programs through CMS, which determines whether nursing homes meet minimum Medicare and Medicaid quality and performance standards by contracting with states to conduct onsite inspections. U.S. DEP'T OF HEALTH AND HUMAN SVCS., *available at* <http://www.medicare.gov/Nursing/AboutInspections.asp>.

¹⁵⁵ *Id.*

¹⁵⁶ Moskowitz, *supra* note 8, at 627.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* at 625.

¹⁵⁹ *Id.* at 625-26.

¹⁶⁰ *See Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline: Hearing Before the Senate Committee on Finance* (2003) (testimony of William J. Scanlon, Director—Health Care Issues), *available at* <http://www.gao.gov/new.items/d031016t.pdf>.

¹⁶¹ *Id.* at introduction.

adequate state review of surveys, large numbers of inexperienced state surveyors, and a continuing issue associated with predictable survey timing of nursing homes resulted in a significant understatement of care problems.¹⁶²

Civil litigation brought on behalf of residents against nursing homes has increased during the last two decades.¹⁶³ The growing number of actions may be the result of multiple factors, including newly available statutory causes of action in many states, the availability of statutory attorney's fees and enhanced remedies for successful litigants and enhanced remedies, a growing elderly population and heightened awareness of the difficulty experienced by the elderly in the institutional setting.¹⁶⁴

F. THE MANDATORY REPORTING REQUIREMENT

Mandated reporting laws have been adopted by many states to protect elder abuse victims who seldom self report.¹⁶⁵ Victims do not report because many feel abusive treatment is normal, or because many are isolated or under the control of the caregiver with no opportunity to seek help.¹⁶⁶ Victims are also reluctant to report family members due to shame, embarrassment, or a lack of third party support.¹⁶⁷ Additionally many are unable to report due to cognitive and physical impairments and many are under the belief that the criminal justice and health care systems are unable to assist them or provide for their needs.¹⁶⁸

In California, a health care provider is required to report if he or she has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse.¹⁶⁹ In a long-term care facility, the report is made to the local ombudsman or the local law enforcement agency; in a place other than a long-term care facility, reports are made to the county APS agency.¹⁷⁰ Currently, forty-three states have adopted mandatory reporting requirements for suspected cases of elder abuse or mistreatment with eight states making reporting voluntary.¹⁷¹

¹⁶² *Id.* at 2.

¹⁶³ Moskowitz, *supra* note 8, at 628.

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at 616. *See, e.g.*, ALA. CODE § 38-9-8 (2005); ALA. STAT. § 47.24.010 (2005); CONN. GEN. STAT. § 17b-451(a) (2004).

¹⁶⁶ Moskowitz, *supra* note 9, at 100.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *See* CAL. WELF. & INST. CODE § 15630.

¹⁷⁰ *Id.*

¹⁷¹ Pratt, *supra* note 14, at 201.

Mandated reporters are individuals who have frequent contact with the elderly; they include nurses, nurse aides, social workers, physicians and mental health workers.¹⁷² After reports are made to the designated state agencies, representatives of the agency will conduct visits and report back to state officials.¹⁷³ Most states maintain the confidentiality of reporters and grant immunity from criminal and civil liability.¹⁷⁴

In California, the categories of mandated reporters have been extended to include any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult,¹⁷⁵ and potentially includes administrators, supervisors, all licensed staff of a facility that provides care or services to the elderly or dependent adults, psychologists, caretakers—both institutional and private—and local law enforcement agencies.¹⁷⁶ Mandated reporters who fail to report abuse or neglect of an elder or dependent adult are guilty of a misdemeanor punishable by up to six months in county jail, fines of up to \$1,000, or both.¹⁷⁷ In cases of willful violations, penalties can be increased.¹⁷⁸ If the alleged abuse occurs in a long-term care facility, reports made to the ombudsman or local law enforcement agency must be forwarded to the State Department of Health Services.¹⁷⁹ Mandated reporters must also forward reports of suspected or known criminal activity in long-term care facilities to the Bureau of Medi-Cal Fraud and Elder Abuse.¹⁸⁰

Despite penalties and state immunity from liability for those reporting in good faith, few mandated reporters comply with the law.¹⁸¹ Physicians have cited fear of court appearances, anger by victim or perpetrator, and potential compromise of confidentiality as reasons for their failure to report.¹⁸² Other reasons for the failure of providers to report abuse include the lack of understanding of procedures for reporting abuse and what constitutes abuse, lack of time to assess patients for

¹⁷² *Id.* at 202.

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ See CAL. WELF. & INST. CODE § 15630. See, e.g., ALA. CODE § 38-9-8; ALA. STAT. § 47.24.010; ARIZ. REV. STAT. ANN. § 46-454(a) (2004); NEV. REV. STAT. § 200.5093 (2004).

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* See, e.g., ALA. CODE § 38-9-10 (2005) (making mandatory reporters who fail to report abuse guilty of a misdemeanor and subject to not more than six months imprisonment or a fine of not more than \$500); ALA. STAT. § 47.24.010 (2005); ARIZ. REV. STAT. ANN. § 46-454(J) (2004) (designating noncompliance as a class 1 misdemeanor); CONN. GEN. STAT. § 17b-451(a) (2004) (designating noncompliance as a class C misdemeanor for the first offense and punishable by a fine of not more than \$500); IOWA CODE § 235B.3(12) (2004) (declaring it a simple misdemeanor to fail to report when required to do so and making the person be civilly liable for the damages proximately caused by such failure).

¹⁷⁸ *Id.*

¹⁷⁹ CAL. WELF. & INST. CODE § 15630(b)(1)(h).

¹⁸⁰ *Id.* § 150630(b)(1)(A)(iv).

¹⁸¹ Moskowitz, *supra* note 8, at 611.

¹⁸² *Id.*

abuse, difficulty in identifying abuse, and personal desire not to be involved in criminal proceedings. Criminal prosecutions for failure to report abuse have been rare and prosecutors are usually unaware of the mandated reporters' failure to report.¹⁸³

There are several exceptions to the mandatory reporting requirements.¹⁸⁴ The first is when a mandated reporter is unaware of independent evidence to corroborate a report of abuse by a victim, and the victim is diagnosed with a mental illness or dementia or is under conservatorship.¹⁸⁵ Under these circumstances, a mandated reporter is not required to report suspected abuse.¹⁸⁶ There is also an exception to the reporting requirement in a long-term care or institutional setting. A mandated reporter is not required to report when there was a proper plan of care, properly provided or executed, and the mandated reporter reasonably believes that the injury was not the result of abuse.¹⁸⁷ Opponents of these exceptions argue that they leave too much discretion to mandated reporters and allow for the decision to report abuse to be made by the care providers who may themselves have perpetrated the abuse.¹⁸⁸

Victims or their families can also attempt to seek redress for a failure to report abuse on their own initiative. Abused victims can sue their health care providers civilly for violation of a criminal statute if the providers fail to report abuse.¹⁸⁹ A plaintiff may be able to establish a presumption of negligence against the mandated reporter by applying the doctrine of negligence *per se*.¹⁹⁰ This presumption can be demonstrated if a person's violation of a statute proximately caused death or injury to another; the death or injury resulted from an occurrence of the nature that the statute was designed to prevent; and the victim was within the class of persons the statute was designed to protect.¹⁹¹ A defendant can defend against this presumption by showing that "it is more probable than not that the violation of the statute was both reasonable and justifiable under the circumstances."¹⁹² Victims injured by repeated instances of maltreatment can sue health professionals for damages because the failure to report often results in additional injury with an escalation of the frequency and severity of abuse over time.¹⁹³

¹⁸³ *Id.* at 614.

¹⁸⁴ Santo, *supra* note 21, at 816.

¹⁸⁵ See CAL. WELF. & INST. CODE § 15630(b)(2)(A)(i)-(iv) (2004).

¹⁸⁶ *Id.*

¹⁸⁷ *Id.* § 15630(b)(3)(A)(i)-(iv).

¹⁸⁸ Santo, *supra* note 21, at 817.

¹⁸⁹ Moskowitz, *supra* note 8, at 621.

¹⁹⁰ *Id.* at 621.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.* at 615.

III. PROBLEMS WITH THE CURRENT LAW AND REMEDIES FOR ELDER ABUSE

Despite the plethora of civil and criminal laws and remedies, and mandated reporting statutes aimed at protecting victims, elder abuse still remains a pervasive problem. While other family violence issues, such as domestic violence and child abuse, have been increasingly recognized and receive sizable federal funding, elder abuse remains under-researched, under-reported and under-funded.¹⁹⁴ This disparity is highly disturbing because elder abuse often triggers the beginning of a downward spiral for the health and well being of an elderly individual and can even shorten the victim's life.¹⁹⁵ While one major problem continues to be underreporting of elder abuse, another problem is the limited response to those reports. It is important that, once the reports are made to the proper authorities, there be an appropriate response.¹⁹⁶ If reporters or victims of abuse perceive that the situation is hopeless or that reporting may increase the potential for abuse, they will cease or withdraw their reports.¹⁹⁷ Equally, those already reluctant to become involved by reporting would discontinue the practice if they believed there would be no discernible result from reporting.¹⁹⁸

Due to the current fragmented system for reporting, detecting, and prosecuting abuse; the lack of training for mandated reporters; the lack of multi-disciplinary collaboration; and the lack of focused attention on the issue, those reporting abuse rarely receive feedback. Moreover, the current system does not promote collaboration between health care providers and law enforcement or other regulatory authorities. Once a report is made, the provider, who frequently has valuable information to contribute, is excluded from the investigation or prosecution process and left to wonder about the outcome. Moreover, instead of rewarding providers for reporting abuse and educating them about their reporting responsibility, our current system seeks to penalize anyone with even an intermittent care or custodial relationship with the victim for the failure to report abuse. The law has gradually expanded the categories of mandated reporters and the natural assumption is that, by threatening criminal prosecution, the number of reports will increase. Yet due to the complexity of social and clinical situations, acts of abuse are easily hidden and buried.

¹⁹⁴ Senator John Breaux & Senator Orrin G. Hatch, *Confronting Elder Abuse, Neglect and Exploitation: The Need for Elder Justice Legislation*, 11 ELDER L. J. 207, 208 (2003).

¹⁹⁵ *Id.*

¹⁹⁶ Suzanne J. Levitt & Rebecca J. O'Neill, *Essay: A Call for a Fundamental Multidisciplinary Approach to Intervention in Cases of Elder Abuse, Neglect, and Exploitation: One Legal Clinic's Experience*, 5 ELDER L. J. 195, 199 (1997).

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

Hence, threats of sanction actually reduce the number of reports and exposure of abuse.

Recognition is another factor impeding the progress of elder abuse prevention. Recognition of elder abuse is often difficult even among professionals directly responsible for preventing it.¹⁹⁹ For example, "a staff member in charge of an abuse registry at a state board of nursing felt that threats, yelling, and cursing by a nursing home employee to a resident did not constitute abuse."²⁰⁰ Another staff person "from a similar agency in another state did not believe that a provider's actions that resulted in 'minor bruises' to a frail resident constituted abuse."²⁰¹ Yet these are clearly examples of possible abuse under all state definitions.

It is also common for health care professionals providing direct patient care to be unaware of what constitutes abuse. The reason is that many health care providers receive inadequate training on detection and recognition of the forms and types of elder abuse. Even providers who know they are mandated reporters are unaware of the legal definitions of abuse, including the responsibility to report any reasonably suspected cases of abuse. According to a National Elder Abuse Incidence Study, only 8.4 percent of all reports to APS programs came from physicians, nurses, or clinics.²⁰² In fact, physicians tend to be the least frequent reporters of elder abuse to state agencies and the least likely group among health care professionals to uncover new cases of abuse.²⁰³

Victims' friends and family often fail to recognize signs of elder abuse as such. Many see what might be evidence of abuse, including bruising, dehydration, and unexplained injuries, as the normal consequences of aging.²⁰⁴ In addition, individuals with cognitive impairments such as dementia may suffer from a higher incidence of abuse, but they are often unable to alert family or friends, or, when they do speak up, their reports are often ignored as being unreliable.²⁰⁵

Even when reports are made, responses can be inadequate. Officials such as ombudsmen and state surveyors who receive reports of abuse in facilities fail to notify law enforcement or fail to encourage the victim to do so.²⁰⁶ In addition, some officials charged with investigating abuse have insufficient training in medical forensics or criminal investigations

¹⁹⁹ Breaux & Hatch, *supra* note 194, at 223.

²⁰⁰ *Id.* at 223-24.

²⁰¹ *Id.* at 224.

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.* Dementia is a condition of deteriorated mentality that is characterized by marked decline from the individual's former intellectual level and often by emotional apathy. NATIONAL LIBRARY OF HEALTH, <http://www.nlm.nih.gov/medlineplus/medlineplusdictionary.html>.

²⁰⁶ Breaux & Hatch, *supra* note 194, at 225.

to perform the task adequately.²⁰⁷ In many instances, agency policies prevent investigations when no alleged perpetrator is named, and abuse investigations are abandoned if there are no witnesses other than the resident.²⁰⁸ Some state agencies also indicate that law enforcement officials are not interested in nursing home cases and lack the knowledge to investigate cases in these settings and therefore are less inclined to prosecute.²⁰⁹

These issues demonstrate that the current laws and remedies to detect and prevent elder abuse have not been sufficiently effective in preventing or addressing the problem. Yet the elder abuse problem cannot be solved without the cooperative efforts of many. Collaborative, multidisciplinary efforts can be more successful in not merely discovering abuse, but also in prosecuting and preventing it.

A truly comprehensive multi-disciplinary approach would involve many organizations having contact with or providing services to the elderly.²¹⁰ Although the difficulty in reaching victims will be an ongoing problem, if organizations work together, the ability to reach a greater number of victims and potential victims can be achieved.²¹¹ A benefit of such a collaborative approach to protect elder abuse victims could also offer a more coordinated infrastructure that is more efficient in detecting and communicating a greater number of cases to law enforcement. The trained case manager can be instrumental in facilitating the collaborative multidisciplinary approach to preventing elder abuse.

IV. THE CASE MANAGER'S ROLE IN DETECTING AND PREVENTING ELDER ABUSE

A. ROLE OF THE CASE MANAGER

The Case Management Society of America ("CMSA") defines case management as "a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes."²¹² Case management does not involve direct patient care but rather the oversight and coordination of care.²¹³ The underlying principle behind case management is that the active involvement and oversight of health

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ Levitt & O'Neill, *supra* note 195, at 195.

²¹¹ *Id.*

²¹² CASE MANAGEMENT SOCIETY OF AMERICA, WHAT IS CASE MANAGEMENT? (June 23, 2002), available at <http://www.cmsa.org/PDF/WhatIsCaseManagement.pdf>.

²¹³ Eric M. Wall, *Case Management in Family Practice: Assuring Cost-Effective Care for High-Risk Patients*, 12 J. AM. BOARD FAM. PRACT. 346, 348 (1999).

care delivery by trained personnel will enable patients to obtain appropriate, quality care in an efficient and cost-effective manner.²¹⁴ Increasingly, policymakers, health plans, hospitals and managed care executives have relied on case management to help reduce burgeoning health care costs and to improve the quality of care for those individuals who are critically injured, suffer from multiple chronic diseases, or who are otherwise at risk.²¹⁵ The frail elderly, disabled, and cognitively impaired individuals are high-risk populations that require ongoing case management involvement.

Case managers are advocates, facilitators, problem solvers, and educators.²¹⁶ They are trained in and are comfortable working in multidisciplinary settings and are accustomed to environments where resources may be limited or absent.²¹⁷ The case management process has been applied successfully in acute care, long-term care, and outpatient settings with diverse populations and disease states.²¹⁸ Well-designed case management programs are a key factor in the effective use of resources and in the management of care for the elderly and disabled.²¹⁹ As the population continues to age rapidly, case management has even greater potential to improve not just individual hospital and health care performance, but also care for the entire nation.²²⁰

Within the health care setting, case management has already been recognized as an effective strategy to improve the quality of care and outcomes for the elderly.²²¹ The case manager's role can be expanded to help coordinate and improve the care, prevention, and detection of elder and dependent adult abuse.

In health care delivery, treatment is frequently fragmented and the overall quality of care is often diluted. The case manager serves a vital role by connecting private and public agencies, disciplines and practitioners.²²² Case managers help focus the system by facilitating the delivery of more individualized, coordinated care—particularly for the elderly population with multiple acute and chronic conditions and disabilities.²²³ Case managers also help patients and their families make informed deci-

²¹⁴ Luu & Liang, *supra* note 28.

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ Jeffrey P. Harrison et. al., *The Effect of Case Management on US Hospitals*, 22 NURSING ECON. 64 (2004).

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ CHERILYN G. MURER & LYNDEAN L. BRICK, *THE CASE MANAGEMENT SOURCEBOOK: A GUIDE TO DESIGNING AND IMPLEMENTING A CENTRALIZED CASE MANAGEMENT SYSTEM* (1997).

²²² CATHERINE M. MULLAHY, *THE CASE MANAGER'S HANDBOOK* (1995).

²²³ *Id.*

sions in dealing with the complexities of the health care system²²⁴ and to obtain the necessary resources and services required for optimal health. The case manager functions to integrate the often disjointed and varied venues of care to ensure better outcomes for the elderly and disabled.²²⁵ While financial factors are considered in planning and coordinating care, the overall goal of the case manager is to promote the health and safety of the elderly and high-risk population whose disease states can be complex, multifaceted and require increased attention and resources.²²⁶ Truly integrated and well-coordinated care has enormous potential to improve quality, safety, and access for those individuals most in need of assistance.²²⁷

Case managers are usually nurses or social workers by trade, but because of the medical assessment, problem-solving, and coordination responsibilities inherent in the case management role, the kind of experience and education that nurses possess have increasingly become essential.²²⁸ To be effective, case managers need broad-based knowledge.²²⁹ They need to be part general health practitioner, part social worker, and part psychologist.²³⁰ In addition to understanding the medical components of a patient's care, a case manager needs to be aware of the psychological, environmental, family, economic, and religious dynamics that can impact the patient.²³¹

The daily role of the case manager involves assessing, facilitating, planning, evaluating, and coordinating health care delivery and services on behalf of their clients,²³² both during their hospitalization and for post-hospitalization needs. Additionally, the case manager is responsible for facilitating communication and coordination between the health care team members and the patient and family with the goal of minimizing fragmentation in health care.²³³ Case management involvement can improve the quality of care for the elderly and vulnerable population while allowing them to maintain the highest level of independence and self-determination.²³⁴ Case management services in conjunction with current laws and existing remedies can significantly help prevent elder and dependent adult abuse and increase the number of reported abuse cases.

²²⁴ *Id.*

²²⁵ Luu & Liang, *supra* note 28.

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ *Id.* at 7.

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.* at 10.

²³² Murer & Brick, *supra* note 221 at 146.

²³³ *Id.*

²³⁴ *See generally id.*

B. ROLE OF THE CASE MANAGER IN RESPONSE TO ELDER ABUSE

The case manager can play a key role in both the detection and prevention of elder abuse. Because many victims of elder mistreatment are out of touch with the outside world, a clinical evaluation and subsequent intervention may be the only opportunity to detect and prevent further abuse.²³⁵ Since the hospital setting may be the only source of initial contact with victims and health care professionals, it is critical that abuse is quickly identified and reported to the proper authorities. Because of the current role of the case manager in assessing, planning, coordinating, monitoring, and evaluating care across settings, the case manager is in an ideal position to respond to the current elder abuse problem.

Case managers routinely screen all patients entering the health care system for potential needs, monitor patients throughout their hospitalization, and provide support, resources and referrals to various providers, agencies, and services. Hence, if case managers can be trained to also evaluate all elder and dependent adults entering the health care system for abuse, to report suspected cases to authorities, and to educate other providers, caregivers, families and patients to monitor for and report abuse, they can serve a critical function in detecting, terminating and assisting in the prosecution of elder abuse.

Beyond screening, the case manager routinely manages and coordinates the care needs of the elderly or disabled patients. Therefore the case manager could readily be involved in the identification and treatment of abuse victims. The case manager is often the first to come into contact with abused victims. He or she may be the first person to suspect abuse and can perform a more comprehensive abuse assessment to determine the extent of the abuse—independent of the caregiver or institutional representative authority or oversight.

Furthermore, with his or her experience, training, and ability to act across sites of care, the case manager is also in the best position to interface with authorities to investigate abuse, provide clinical assessments and information, complete forms and report abuse, and provide support and services to the victims.²³⁶ The case manager is also equipped with information and resources that can assist innocent caregivers. By provid-

²³⁵ *Id.*

²³⁶ Case managers are usually licensed registered nurses. Effective case managers have three to five years of direct care experience, preferably within the specialty area in which they case manage. The best case managers are extremely bright, interpersonally gifted with patients and families, and have collegial communication skills with staff and physicians. The ability to multi-task is a must, in addition to having a strong foundation in principles and utilization review, and a working knowledge of area facilities, providers, and benefits structure. See Alison P. Smith, *Case Management: Key to Access, Quality, and Financial Success*, 21 NURS. ECON. 237 (2003).

ing these key individuals with additional education on elder abuse detection, prevention and reporting, they can be instrumental in helping to uncover cases of elder abuse and mistreatment, providing education about the significance of the problem, and getting cases of abuse to the proper authorities for prosecution.

The case manager positioned either in the emergency room where victims of abuse more often first present, or within the hospital or clinic setting, can recognize the often hidden signs of elder abuse. The case manager can rapidly screen all elderly and disabled individuals for signs and symptoms of abuse and can monitor for cases of potential or suspected abuse. If the case manager suspects abuse, he or she can then conduct a more comprehensive medical and psychosocial assessment of the individual to determine the circumstance and type of abuse suspected. During these assessments, the more subtle signs of elder abuse may be detected. If his or her suspicions are confirmed, the case manager can then report suspected cases to the relevant authorities. Critically, the goal for the case manager is not to prove abuse; instead, the case manager can utilize informed judgment to gather clues that point toward a reasonable suspicion of abuse.

The case manager can then also collaborate with law enforcement authorities, prosecutors, and the local APS agency in investigating suspected abuse. The case manager can use his or her clinical expertise to provide crucial information to prosecutors and governmental agencies for their investigation, and as an expert, assist in its successful prosecution. The case manager is also ideally situated and trained to coordinate all the agencies and facilitate communication between the various agencies and authorities.

As noted above, the case manager, with proper training on clinical signs and symptoms, reporting procedures, legal mandates, and reportable types of abuse can quickly identify and report abuse as part of his or her daily role. Beyond reporting abuse, the case manager has the best training and background to intervene immediately on the victim's behalf. The case manager is able to draw upon a variety of resources to ensure the patient receives protection and the appropriate level of care once the abuse has been identified. For example, the patient can be taken out of the abusive situation by hospitalization, or he or she can be transferred to a safe environment equipped to care for his or her needs.

In addition to his or her role in screening for cases of abuse and mistreatment and intervening on behalf of the abused victim, the case manager can play a vital role in prevention. The case manager is usually alert to the changing needs of the patient, the quality of the care received, and, importantly, warning signs of family caregiver burnout, due to his or her expertise and involvement in cases across settings. Often the case

manager has knowledge of additional support services and can offer such services to relieve part of the burden on the caregiver.²³⁷ If the case manager is faced with a situation of caregiver stress, burnout, financial hardship, or a lack of support where the potential for abuse can be great, he or she can intervene to prevent abuse from occurring. Under these circumstances, the case manager has a variety of resources he or she can draw upon to help alleviate the situation. For example, the case manager can make a referral for home-health services under the appropriate insurance benefit, refer the caregiver to various support groups, offer resources for respite care, and provide financial assistance information. The case manager can also collaborate with individuals and their families to determine if other community services such as home-delivered meals, chore services, transportation, or legal assistance can help to maintain the older person's independence and autonomy and reduce the likelihood of premature institutionalization, abuse and neglect.²³⁸ Many elders welcome assistance when services are offered or made known to them.²³⁹ Hence, case managers can proactively diffuse high abuse situations to prevent abuse.

C. TYPICAL ELDER ABUSE SCENARIO WITH CASE MANAGEMENT INVOLVEMENT

1. *Facts*

John, an 85 year-old man with a history of dementia, presents to the hospital emergency room ("ER") after a fall. The medical work-up reveals no acute injuries but John is having difficulty walking due to the pain in his legs. John appears unkempt, disheveled and malnourished. John has no family but he does have a full-time, live-in caregiver at home and a conservator who is a long-time friend and makes health care decisions for John. The physician, after determining that John is only slightly dehydrated and does not require hospitalization, asks the case manager to be involved in evaluating the services and resources available to John. The physician and the nurse taking care of John in the ER are uncomfortable with sending John home since it appears he is not well cared for; they request for case management input. The case manager interviews John, his caregiver, and the conservator separately and discovers that John has a large sum of money that can be used towards his care; however the conservator does not have control over John's finances and wants information from the case manager on obtaining financial control of John's money. The conservator appears unaware that John may be receiving inadequate care from the caregiver that the conservator

²³⁷ Mullahy, *supra* note 222, at 335.

²³⁸ Santo, *supra* note 21, at 835.

²³⁹ *Id.*

hired. The case manager, after completing his/her evaluation, is also concerned about the care John is receiving and believes he needs some sort of ongoing follow-up and intervention by case management.

2. *Result: Traditional*

Under our existing system, any provider with care responsibility for an elderly person must report any reasonably suspected cases of abuse. Because the nurse, the physician, the paramedics transporting John to the ER, and the case manager were providing an intermittent level of care for John, they are all responsible for reporting the suspected abuse individually, unless they have an agreement that one person will report the abuse. At first glance, it is not clear that there was abuse here, even though coordinated assessment could reasonably conclude there was, and since most providers have not received adequate training on what is considered abuse, if no one completes a report, they are all potentially liable and could be prosecuted criminally for the failure to report the suspected abuse. More importantly, the lack of coordination, knowledge, and/or information will likely result in no report at all and continuance of the status quo for John.

There are troubling aspects to John's situation that point to potential neglect and financial abuse. Even if a report is contemplated, administrative barriers are extant. For example, if the report is made to the local APS agency as mandated, the provider must call the agency immediately or soon after and also complete and mail an abuse reporting form within two working days of the phone call. From there the provider is usually left out of the process and will never know whether the abuse was substantiated or whether the case will be referred for criminal prosecution of the abuser. Under this current system, it is likely that no one will recognize, report, or follow-up with the situation. The likelihood of prosecution is low.

3. *Result: Reformed*

Under the system proposed in this article, the case manager with training on abuse will actively screen all patients entering the system for possible abuse, including John. He or she will intervene whenever there is a suspected case of abuse—whether or not he or she has received a referral from a provider. John's case would have been received and discovered as a potential abuse case even if the case manager had not received a direct referral from the physician or another source. Factors such as John's disheveled and unkempt state, malnourishment and focus of his conservator on obtaining access to John's money would be noted by the case manager. He or she would also be able to make additional investigative and clinical queries about John to assess the possibility that

he has been or is being abused. The case manager would then report this information to APS and also directly to a prosecutorial agency for possible criminal action against the abuser. The case manager would work closely with APS and the prosecutorial agency as an expert and advocate for John. The case manager would help coordinate efforts and facilitate multi-disciplinary collaboration and communication in the relevant placement and treatment of John while also monitoring his needs and providing feedback on his case to his health care provider. The case manager would also take action as necessary to provide support, counseling, and referral to a variety of eldercare resources to protect John, such as a transfer to a skilled nursing facility where he can receive further care or to an alternative safe setting for follow-up. Hence, the case manager is involved in continuously monitoring his situation over time to ensure his safety. This task is particularly important in cases such as John's where there is a lack of family support, the individual is vulnerable to abuse because of his impaired cognitive status, and there is no one individual designated to advocate on his behalf. Prosecution in this circumstance, if abuse is substantiated, can occur in a coordinated, efficient manner with a fully informed, clinically trained case manager.

CONCLUSION

Despite the increased awareness and remedies available to victims, elder abuse and mistreatment continue to affect a significant number of the most vulnerable and frail elderly and disabled individuals. It remains one of the most unrecognized and underreported social problems today.²⁴⁰

Although there is federal and state legislation aimed at protecting the elderly and dependent adults from abuse and mistreatment, there remains a disparity between the reality of elder abuse and the practical viability of current efforts to prevent abuse, to assist the victims,²⁴¹ and to prosecute the perpetrator. A case manager specially trained in the care of the elderly and in recognizing signs of abuse can be instrumental in detecting and helping abused victims at the point of care and beyond. The case manager can also work closely with social service agencies and law enforcement to effectively prosecute elder abuse offenders while also providing information to health care providers and caregivers alike. In this way, a much greater number of cases of elder abuse can be detected while a greater number can be treated or avoided. Such a coordinated system would be a vast improvement over the current fragmented and ineffective system that detects few cases of elder abuse, reports even fewer, and prosecutes almost none.

²⁴⁰ Skabronski, *supra* note 52, at 629.

²⁴¹ *Id.* at 633.