Newsletter
National Center on Elder Abuse

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Pennsylvania Funded for Exploitation Pilot, Training Institute

Pennsylvania will be enhancing its adult protective services system through two grants it has received, worth a total of $372,000.

One grant, awarded by the Pennsylvania Commission on Crime and Delinquency, will help establish the Older Adult Protective Services Training Institute within Temple University's School of Social Administration. Both protective services workers and law enforcement officials will be trained by the Institute.

The second grant, from the Administration on Aging, is to develop a pilot project to increase the ability of area agencies on aging (which provide protective services in Pennsylvania) to look into and resolve allegations of financial exploitation. Currently, about 21% of Pennsylvania APS cases allege financial exploitation, and the pilot project will include advanced investgaive training and consultative reources for protective services staff.

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Mental Health Services for Elders Funding Available

June 19, 2002 is the deadline for proposals to Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services for increasing service capacity for older persons with priority mental health needs.

"The purpose of this initiative is to increase the capacity of cities, counties, and tribal governments and not-for-profit direct service providers to provide prevention, early intervention, and treatment services to meet emerging and urgent mental health needs of older persons. In tandem with the

direct provision of services the program provides resources for communities to build and/or expand the local and regional service system infrastructure that will help support prevention, early intervention, and treatment services having a strong evidence base."

Up to nine proposals will be funded out of a allocation of $5 million. For further information, go to the SAMHSA website at www.samhsa.gov/grants/grants.html and look for grant opportunity SM-02-009. ♣

Special Section: Abuse in Nursing Homes

Senate Hearing on Physical, Sexual Abuse in Nursing Homes Held

On March 4, 2002, the Senate Special Committee on Aging held a hearing entitled, "Safeguarding Our Seniors: Protecting the Elderly from Physical and Sexual Abuse in Nursing Homes."

There were two centerpieces of the hearing. One was a newly-released General Accounting Office (GAO) report on the "adequacy of protections afforded nursing home residents and the responsiveness of federal, state, and local agencies to allegations of resident abuse." (See following article.)

The other centerpiece was three individual horror stories. The testimony began with a videotape of Helen Love, a nursing home resident abused by a nurse aide, who died of a broken neck caused by the abuse two days after the videotape was made. Her son testified that the nursing home actively opposed getting his mother's injuries cared for, and said the family got "no assistance" from social service agencies. The family discovered that the perpetrator had been dismissed from two previous nursing home positions due to aggressive behavior toward residents. Because the aide plead guilty to elder abuse immediately after the woman died and before a manslaughter charge could be brought against him, he drew a sentence of only one year in county jail.

The second case was also fatal. Helen Becker Straukamp was attacked by another resident. Like the aide in the Love case, this resident also had a long history of violent behavior.

The third case was a rape of a 38-year-old brain-injured resident by a nursing home employee. That rape went undiscovered, as did the resulting pregnancy, until nursing home staff found the resident and her newborn in the resident's bed.

After the individual cases were discussed, a panel of professionals was seated. First up was a representative of GAO, who basically summarized the report reviewed in the next article. Also on this panel was an Arkansas coroner. He testified that after finding several cases where a death the nursing home reported was the result of natural causes had actually been caused by medication errors or asphyxia, he helped pass a law requiring that all deaths of nursing home residents be reported to the coroner. Since the July 1, 1999, implementation of the law, his office has found suspicious 56 of the 2400 deaths they've reviewed, believing they were likely caused or hastened by institutional abuse or neglect.

Henry Blanco, Program Administrator for the Arizona Aging and Adult Administration, spoke on behalf of the National Association of Adult Protective Services Administrators (NAAPSA). He discussed

several cases and noted that 18% of Arizona's APS investigations involve allegations from long term care facilities. NAAPSA offered the Committee ten recommendations for addressing both institutional and domestic abuse.

A recurring theme of the hearing was the extent to which law enforcement agencies are or should be involved in responding to institutional abuse cases. Senator Breaux opened the hearing by reading from a letter sent to the Committee by the International Association of Chiefs of Police (IACP). Declining to testify at the hearing, the IACP wrote, "…the IACP membership has not yet taken a formal policy position on this issue." Breaux chastised that response: "Too many police departments do not have abuse of seniors in nursing homes anywhere on their radar screen. I think it is clear that we have much work to do to ensure that they are better trained and sensitized to the crimes against seniors in institutions. Moreover, it is essential that [abused residents] not be treated differently from anyone else outside institutions or treated differently because of their age."

The GAO witness also discussed law enforcement involvement in institutional abuse, noting that many of the law enforcement officials GAO interviewed knew of few abuse cases, and a number had no idea that state survey agencies have anything to do with investigating such cases. The report found that successful prosecution of perpetrators was severely hampered when law enforcement was not immediately involved so that evidence could be collected and preserved.

The last witness, from the American Health Care Association (AHCA), addressed several law enforcement issues. She said that local law enforcement agencies and Medicaid Fraud Control Units (MFCU) need "education and training…on the nursing home environment, on types of patients, and on staffing situations" so they can better conduct investigations and make appropriate findings. Related to that, she reported that AHCA wanted a standardized definition of abuse that clearly distinguishes between appropriate but uncomfortable clinical procedures and abuse. With regard to reporting to law enforcement, she said AHCA wanted a single point of contact for anyone to report abuse, "preferably to the survey agency." It should be that agency's responsibility to then notify law enforcement.

Copies of the written testimony and a videotape of the hearing itself are available at the website http://aging.senate.gov/events1.htm. ♣

General Accounting Office Studies Nursing Home Abuse Problems

The General Accounting Office (GAO) released a new report, "Nursing Homes: More Can Be Done to Protect Residents from Abuse," at a March 4, 2002 Senate hearing on the subject.

GAO studied 158 physical and sexual abuse allegations lodged against nursing homes in Georgia, Illinois, and Pennsylvania in 1999 and 2000. The study looked at the existing systems to both prevent and address abuse.

With regard to prevention systems – conducting background checks and tracking abusive employees -- GAO found a number of problems. Although all three of the studied states require nursing homes to conduct criminal background checks on potential employees, only one ever requests federal background checks that might pick up convictions from other states (and that

state only requests such checks for people who have lived outside the state within the past two years).

GAO noted several limitations of existing nurse aide registries:

- They are typically not notified when criminal backgrounds are uncovered, so do not include such findings.
- They cover only nurse aides, even though 10 of the 158 cases GAO looked at were allegedly perpetrated by non-licensed, non-certified employees.
- Seventeen percent of the cases GAO looked at had not made it to the nurse aide registry for at least 10 months (and up to 2+ years) after the allegation was made.
- At least one web-based registry of confirmed abuse by nurse aides did not include all known confirmed cases.

GAO also found a number of problems with the systems set up to address abuse once it has occurred. For one thing, about 50% of abuse allegations known to nursing homes were referred to the state survey agency outside the two-day mandated reporting window. This is problematic because crime evidence decays quickly. States were found to differ in their interpretation of the Centers for Medicare and Medicaid Services (CMS) definition of abuse as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." One of the studied states tends to not class as "willful" physical harm inflicted by an employee who is responding to having just been hit by a resident. Another state tended not to take action when there were no apparent physical injuries.

Sanctions against nursing homes for abuse were relatively rare. Of the 158 case files GAO reviewed, only 26 homes were cited for deficiencies related to the abuse. Only one civil monetary penalty was recommended, and even it was reduced on appeal.

The report concludes with five recommendations that could be implemented by the CMS administrator:

- Ensure that state survey agencies immediately notify local law enforcement agencies or MFCUs when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.
- Accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state agencies to ensure that these numbers are prominently listed in local telephone directories.
- Systematically assess state policies and practice for complying with the federal requirements to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.
- Clarify the definition of abuse and otherwise ensure that states apply that definition consistently and appropriately.
- Shorten state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.

For the most part, CMS said it would implement or consider four of the recommendations. Regarding the definitions of abuse, CMS restated that the states should use the federal definition when performing a federal survey. GAO felt this did not go far enough.

Senate Special Committee on Aging Chair John Breaux issued a news release at the end of the March 4 hearing (see previous article) calling upon CMS to "issue a monthly written report to the [Senate Special] Committee [on Aging] on its progress implementing the recommendations of [the] General Accounting Office Report." *NCEA Newsletter* will cover such progress reports if and as they're made public. ♣

New Quality of Care Measures for Public Use Released by CMS

The Centers for Medicare and Medicaid Services (CMS) rolled out new quality of care measures for nursing homes in Colorado, Florida, Maryland, Ohio, Rhode Island, and Washington on April 25, 2002.

Nine quality measures were chosen after a very lengthy analysis. Six of the measures are related to long-term residents:

- % of residents experiencing an increased need for assistance from one assessment to the next;
- % of residents with pressure sores;
- % of residents who lost more than 5% of their bodyweight in a month;
- % of residents with very bad pain at any time or moderate pain every day for 7 days;
- % of residents with infections; and
- % of residents in physical restraints.

Three of the measures are related to short-stay residents (those in the facility for fewer than 90 days):

- % of short-stay residents who improved in walking;
- % of short-stay residents with very bad pain at any time or moderate pain every day for 7 days; and
- % of short-stay residents with delirium.

The quality measures are calculated based on the Minimum Data Set assessment (MDS) that facilities do on each resident upon admission and at three-month intervals.

Results were supposed to be adjusted to take into account three variables:

- Certain types of cases are excluded. For instance, residents are excluded from the pressure sore count for three months if they entered the facility with a sore, and those with end stage renal disease are excluded from the weight loss measure.

- Certain individuals are excluded. CMS told nursing home administrators the data, "Control[s] for certain individual level factors that may place a resident at greater risk for a condition (e.g., taking into account the fact that some residents may lose weight because they refuse to eat or are physically abusive and, therefore, more difficult to feed)."

- Case mix adjustments are made. CMS says: "This third method of adjustment takes into account features such as whether a facility treats a large number of patients with certain conditions, [such as] a nursing home with a special wound care unit."

However, CMS reported in a letter dated April 4, 2002 to the administrators of the

affected nursing homes that the third adjustment was withdrawn until it could be validated.

Results were publicized in two ways. First, they are available on the Nursing Home Compare website (www.medicare.gov). Second, advertisements were run in 30 newspapers within the six states showing bar graphs on three measures for each area's nursing homes: pressure sores, needing additional assistance, and pain (long-term residents).

This is a pilot project, part of the overall CMS Nursing Home Quality Initiative. Users and advocates are encouraged to provide feedback to NHQualityInitiative@cms.hhs.gov. For further information on the project, both of the following websites include a great number of relevant documents: www.cms.hhs.gov/providers/nursinghomes/nhi and http://nccnhr.newc.com/public/50_154_3242.CFM. ♣

Abuse Investigations to be Added to Nursing Home Compare Website

At the same time that the Health and Human Services' "Nursing Home Compare" website (www.medicare.gov) was being added to (see previous story), Congressman Henry A. Waxman and Senator Charles E. Grassley issued a report criticizing the website for not including the results of investigated complaints.

Currently the website rates over 16,000 nursing homes nationwide on the basis of how many violations of federal standards were found on each institution's latest regular inspection. However, a study by the minority staff of the Special Investigations Division of the House Committee on Government Reform found that between October 1, 2000 and December 31, 2001, there were 25,204 documented violations of federal health standards that were excluded from the Medicare website.

More specifically, the report noted that between October 1, 2000, and December 31, 2001, there were 1,923 nursing home violations classed as "immediate jeopardy," or having caused or having the potential to cause death or serious injury to residents. Nearly 60% of these – 1,138 violations -- did *not* show up on the website because they were documented during complaint investigations rather than during regular inspections.

The report says, "There are 871 nursing homes in the United States that were cited for immediate jeopardy violations between October 1, 2000 and December 31, 2001. Over half of these nursing homes (471 facilities) are not identified on 'Nursing Home Compare' as having any immediate jeopardy violations. Over 1,300 nursing homes that had actual harm violations are misidentified on 'Nursing Home Compare' as having no actual harm violations."

In late April, CMS Administrator Thomas A. Scully wrote Representative Waxman that CMS has "developed a plan to display deficiencies that result from complaint investigations on the Nursing Home Compare Web site…Our plan is to make these data available on the Web site in May." In the meantime, the minority office of the Committee on Government Reform has added to its website a searchable database containing all the health violations found during complaint investigations from the period October 1, 2000 to February 11, 2002. Both the report and the database can be found at www.house.gov/reform/min/. ♣

Phase II of Minimum Nurse Staffing Ratios Report Drafted

A report on the second phase of a study Congress mandated the Department of Health and Human Services (HHS) undertake in 1990 on the appropriateness of establishing minimum caregiver to resident ratios for nursing homes has been drafted.

Phase I of the study was released in 2000 (it's available at www.hcfa.gov/medicaid/reports/rp700hmp.htm). The National Citizens' Coalition for Nursing Home Reform (NCCNHR) characterized this report as finding that "more than half of nursing homes do not have enough nurses and nursing assistants to avoid harm to residents and that more than 90 percent do not have enough nursing assistants to provide *good* care." [emphasis in the original]

Phase II was designed to look at two questions: "Is there some ratio of nurses to residents below which nursing home residents are at substantially increased risk of quality problems? Conversely, is there some ratio of nurses to residents above which no additional improvements in quality are observed?"

The official report on the Phase II findings had not been released at press time, although there have been Congressional calls for HHS to release it. A draft of the report is available through the minority office of the House Committee on Government Reform at www.house.gov/reform/min/inves_nursing/nursing_cms_rep.htm. This draft concludes that depending on an individual facility's resident mix, quality of care "is improved with incremental increases in staffing" up to the thresholds of:

- 2.4 – 2.8 hours/resident/day – nurse aide
- 1.15 – 1.30 hours/resident/day – licensed staff (RNs and LPNs combined)
- 0.55 – 0.75 hours/resident/day – registered nurses

Once staffing reaches those levels, further increasing staff levels does *not* improve quality of care. The report notes that 97% of nursing homes currently fail to meet at least one of those standards.

Phase II also looked at whether there are "nurse aide staffing thresholds minimally necessary to provide *care processes* consistent with the OBRA '87 *optimal* standards and related regulations and guidelines." [emphases in the original]

Researchers looked at the time nurse aides require to complete five "key care processes": dressing/grooming independence enhancement; exercise; feeding assistance; changing wet clothes and repositioning; and providing toileting assistance and repositioning. They said they "conservatively estimated that in 2000 over 91 percent of nursing homes have nurse aide staffing levels below that identified as minimally necessary to provide all the needed care processes that could benefit their specific resident population."

The authors stop far short of recommending minimum staffing levels. Instead, they concluded that "we do not think there is currently sufficient information upon which to base a Federal requirement for all certified nursing homes," and that an additional "analysis is needed of the quality improvement/cost tradeoff as staffing increases up to the threshold."

Therefore, the report concludes with recommendations that HHS should conduct three more specific studies, develop and test specific protocols on how to organize and

manage nurse aides to achieve "the high productivity that would make any level of staffing more effective," establish a multi-agency task force to address nurse aide training issues, and establish a new provider requirement of electronic submission of staffing data based on payroll data and invoices from contract agencies, to allow better tracking of staffing levels. ♣

Share Your Good Work

Have you developed a training manual, curriculum guide, publication or videotape? Does your state publish an annual APS report? Have you completed a report on a demonstration or research project? Share your materials with the Clearinghouse on Abuse and Neglect of the Elderly (CANE) so that others can learn from, and about, you. Please send a copy to CANE, Department of Consumer Studies, University of Delaware, Newark, DE 19716.

Article Review: "Sexual Abuse of Nursing Home Residents"

Even nursing home residents who cannot verbalize their victimization often show signs they've been sexually assaulted, say researchers Ann Wolbert Burgess and colleagues.

Their article, "Sexual Abuse of Nursing Home Residents" was published in the *Journal of Psychological Nursing*, Vol. 38, No. 6 (June 2000), pages 10 – 18. The researchers examined extensive records on twenty sexual assault cases that had been involved in civil suits. Four of the victims were under 65, and two were older men. Five of the residents could ambulate on their own; the rest used a wheelchair or were bedbound. Twelve had a primary diagnosis of dementia or Alzheimer's disease.

In all 20 cases, someone other than the victim was involved in reporting the rape to nursing home administration. Seven of the victims informed a family member, and three informed a staff member. Six incidents (three perpetrated by staff members, three by other residents) were witnessed by staff, and staff suspected a seventh. In four cases, staff or family members detected physical "clues": pregnancy, venereal warts, and serious pelvic bruising with reports of pain.

In only three cases did the perpetrator remain unidentified. In half the cases, there were no forensic rape examinations, "usually because of delayed reporting, not believing the resident, or failing to follow protocol." Of the ten examinations that were done, six produced positive evidence; two had vaginal bleeding but no sperm; and two revealed no physical or forensic evidence.

Victims frequently showed trauma-related symptoms related to the assault. These included:

- Expressions of fear of male staff;
- Avoidant behavior with male staff;
- Withdrawn behavior (cessation of usual activities);
- Staying near the nurses station or lying in bed in a fetal position;
- Repeating statements made during the assault;
- Sexualized behaviors;
- Wearing two or three layers of clothing to bed;
- Persistent requests to go home and leaving the nursing home;
- Statements such as believing one's marriage is over, newly-initiated calling for one's dead sibling, talk of

"carrying a baby", and talk of being caught and displeasing parents;

- Refusal to sleep in bed, either hiding on the floor or curling up under the bed;
- Refusal to take medications, eat, have vital signs taken, or allow medical treatments;
- Refusal to wear usual makeup and costume jewelry; and
- New complaints of feeling cold (made by more than half of the victims).

The researchers noted that rape trauma syndrome has two distinct variations, both of which were shown by these sexual assault victims. One type is compounded rape trauma, in which "victims have a past and/or current history of psychiatric, psychosocial, or physical problems that compound the effects of the sexual assault." The second is silent rape trauma, in which "expression of assault-related symptomatology is muted, undetected, or absent."

However, because so many of the residents did show trauma-related symptoms, the researchers concluded "staff must be trained to detect the emergence of symptoms, including noteworthy changes in baseline behavior in victims who are likely to exhibit symptoms in a muted or 'silent' fashion."

A single copy of this article (File No. K4285-8) can be obtained from the Clearinghouse of Abuse and Neglect of the Elderly. Send a check for $1.60 made out to CANE-UD to:

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University of Delaware
Newark, DE 19716
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Florida Reviews Video Camera Use as Nursing Home Abuse Prevention

"In conclusion, the likely deterrent effect on resident abuse and neglect, together with the benefits to management, residents and their families and friends, suggest that the voluntary use of cameras in nursing homes and resident rooms – similar to what is allowed under the new Texas law – would work well in Florida. Legislation should allow Floridians to make this choice."

So ends a January 2002 report, "Cameras in Nursing Homes," prepared at the behest of the Florida Legislature by the Agency for Health Care Administration and Office of the Attorney General.

Although the 20-page document focuses specifically on Florida law, case precedents, and experience, the analysis and appendices would be useful to any jurisdiction debating the use of video cameras in nursing homes. The report reviews current use of video cameras across the country, initiatives in other states, a brief overview of quality of care issues, and a lengthy review of legal issues related to privacy rights of residents, roommates, employees, visitors, and the nursing home itself. There is also discussion of attorney-client issues, civil liability, wiretapping concerns, and evidentiary issues. In the economic impact section, camera costs, staff turnover, and liability insurance issues are reviewed (an appendix includes two letters from insurers vehemently opposing the installation of video cameras).

A large section of the report gives brief thumbnails of testimony given by residents, advocates, nursing home administrators, and others at a public forum on the issue held October 25, 2001 at the Stetson University Law School. One of the most intriguing

witnesses was Cindy O'Steen, the owner and administrator of a 36-bed facility, who voluntarily installed cameras in her facility's common areas. She reported that the cameras have been so positive that she could think of no negatives associated with them. Their use had allowed her to terminate workers who were not performing satisfactorily, better train workers in techniques such as repositioning residents, and enjoy drops in the facility's premiums for both liability insurance and workers' compensation insurance. The report on a site visit to this facility expands on her testimony, noting that because the cameras are connected to the Internet, the owner/manager can monitor the facility from home, and residents' families can observe and listen to the common areas of the facility at any time. Staff reportedly like the cameras because they help ensure no one slacks their work off on co-workers.

The website where the report is available for downloading (www.fdhc.state.fl.us/cinh/) also includes copies of Texas documents, including legislation permitting the installation of cameras, proposed legislative rules, and sample consent forms. ♣

Research Review

Abuse in Nursing Homes

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Although the field of elder abuse prevention has historically focused on abuse in domestic settings, interest in abuse against residents of nursing homes has been rising. But as advocates call for aggressive action to ensure protection for this vulnerable population, they are discovering that little is actually known about the extent, nature and causes of nursing home abuse that could guide them in these efforts.

The forms of elder abuse found in nursing homes mirror those found in domestic settings; they include homicide, physical and sexual assault, neglect, inappropriate restraint, financial abuse, isolation, verbal threats and intimidation. In addition, nursing home abuse includes institutionalized practices that result in chronic neglect, substandard care, overcrowding, authoritarian practices, and failure to protect residents against untrained, troubled or predatory workers, or against abusive residents or visitors. Subtle forms of abuse that have been explored include denying residents the right to exercise personal choice in such matters as when they want to eat, get up or go to bed; pressuring residents to participate in activities; and "labeling" troublesome individuals, resulting in depersonalized treatment and exclusion (Meddaugh, 1993). It has been further been noted that facilities engage in discriminatory practices, such as emphasizing activities that favor more capable residents (Hall and Bocksnick, 1995).

What is known about the extent and nature of abuse has been drawn from a few scientific studies, surveys on the quality of care, and reports from governmental agencies that handle complaints about nursing homes, including the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), Medicaid Fraud Control Units, and the Long Term Care Ombudsman Program (LTCOP). Several curriculum developers, in surveying workers about their information needs, have elicited information about workers' experience with abuse, further contributing to the knowledge base (Hudson, 1992; Braun et al, 1997).

Myriad problems with the research on nursing home abuse have been cited. These

include variations in definitions and methodologies, which prevent researchers from comparing or aggregating results; difficulties in distinguishing abuse from substandard care or bad practice; and "contextual differences" that limit the usefulness of cross-country or cross-cultural comparisons. Perhaps the most consistent "finding" among researchers is that a national picture of abuse and neglect is not yet available.

Most of the research has focused on abuse by nurse aides. This does not suggest that other employees are less likely to abuse but, rather, reflects the fact that nurse aides comprise the largest number of employees and have the greatest opportunity to abuse. Most studies assume that abusive nursing home employees are not acting in a malicious, premeditated manner, but rather, are responding to the highly stressful nature of the work, which is attributed to insufficient staffing and time to complete tasks, interpersonal conflict and aggression by residents. One of the basic features of staff experience in nursing homes, in fact, appears to be the threat of verbal aggression and physical violence by residents. One investigator observed that within a single month, 84% of nursing aides surveyed had been sworn at or insulted and 70% had experienced some form of physical aggression, including being pushed, grabbed, shoved, pinched, hit, kicked, or hit by objects (Goodridge et al, 1996). Other sources of employees' stress include aggression by supervisors and residents' family members.

Despite the paucity of data, it is widely agreed that abuse and neglect is a common occurrence in nursing homes, and that it is significantly underreported. In the first random sample survey, Pillemer and Moore (1990) conducted confidential interviews with 577 nurses and aides, which revealed that 10% of the respondents had themselves committed one or more acts of physical abuse in the past year, and 40% admitted to psychologically abusing residents. The most common forms of physical abuse were restraining patients beyond what was needed to ensure their safety (6%); pushing, grabbing, shoving or punching (3%); hitting the patient with an object (2%); and throwing something at the patient (1%). The most common forms of psychological abuse were yelling, swearing or insulting residents, denying them privileges or threatening to hit or throw something. A full 36% of those interviewed indicated that they had witnessed other employees physically abuse residents, and 81% had observed at least one incident of psychological abuse in the last year. Braun et al (1997) reported that 14% of nurse aides surveyed had observed abuse and neglect daily, and a study of workers in Sweden (Saveman et al, 1999) revealed that 11% of the workers knew of at least one elder abuse incident in the last year (although this sample included home care workers as well as employees of long term care facilities, most worked in nursing homes).

Studies to explore causes or predictors of abuse typically define four categories of variables. "Structural variables" include societal, cultural or economic factors such as the low esteem in which the elderly are held and the insufficient labor force of workers. "Environmental factors" refer to the nursing home setting and include staffing levels, staff turnover, management, and ownership status.

Most studies of the causes of abuse in nursing homes have focused on characteristics of patients, workers or interactions between the two. Some have assumed that patients with cognitive and physical impair-

ment, as well those who have infrequent visitors, are at greater risk for abuse and neglect (Menio, 1996), although these assumptions have not been substantiated. Patient aggression has been shown to be a particularly significant predictor of both physical and psychological abuse (Pillemer & Moore, 1990; Goodridge et al, 1996). Not only do staff strike back against aggressive residents, but severely confused and aggressive residents are more likely to be denied opportunities for personal choice (Meddaugh, 1993).

Perpetrators' characteristics that have been explored include age, gender and attitudes toward the elderly. In the case of psychological abuse, age has been shown to be a significant characteristic, with abusers being younger than non-abusers (Pillemer & Moore, 1990). Employees' negative attitudes toward residents are also a significant factor in psychological abuse. Psychologically abusive staff are more likely to view patients as "needing to have everything done for them," "waiting to die" and "like children who sometimes need to be disciplined" (Pillemer & Moore, 1990). Employees' "burnout," which is described as a progressive physical and emotional exhaustion resulting from prolonged involvement with people, has been found to be strongly associated with physical and psychological abuse. Burnout is believed to create negative job attitudes and perceptions and a loss of empathy for patients.

In a survey of nursing abuse cases prosecuted by Medicaid Fraud Control Units, 56% of the perpetrators were males; however, it should be noted that this study involved prosecuted cases, which are still relatively rare, suggesting that these abusers committed more serious acts of abuse or, perhaps, reflecting biases on the part of law enforcement (Payne & Cikovic, 1995). Abusers have been observed to be more aggressive, dominant, egoistical, sadistic and reactive, and some researchers have noted that abusers are more likely than others to lose their tempers and to have mental health problems (Shaw, 1998; Saveman et al, 1999).

Shaw (1998) suggests that workers' personality traits and circumstances influence their ability to cope with patients' aggression and determine whether they will respond negatively. According to Shaw, certain workers develop "immunity," or tolerance to aggression by residents; the ability to develop and sustain immunity is tied to such personality traits as resiliency, patience, and placing value on caring for others. Factors that undermine immunity include fatigue, financial stresses and substance abuse. Some workers never develop immunity.

Although abuse clearly has consequences for victims, abusers and society, little attention has been paid to abuse sequela. Saveman et al (1999) observed that abused residents become more fearful, aggressive, confused and withdrawn. The consequences for individual perpetrators have typically been termination from employment or disciplinary action. When individual workers are prosecuted, the sentence they are most likely to receive is probation (68%), with 23% serving time in jails or prison. Persons convicted of sexual abuse are more likely than other offenders to receive prison sentences. Abuse and neglect by facilities have typically been handled through regulatory and licensing agencies that fail to adequately maintain compliance with federal standards (USGAO, 2002).

Menio (1996) has shed light on what happens when a major corporate nursing home is criminally prosecuted. After the state's Attorney General issued the first of

several indictments arising from the neglect of residents, it set in motion a series of events that had marked impact on the quality of care in the area. Sanctions were imposed by the state's Department of Health, which included temporary management and greater attention to applicants' quality of care histories when granting Certificates of Need (required to open new facilities). Fines from the criminal case were used to establish a "special ombudsman" program. Owing to special advocacy efforts, the displacement of residents was avoided.

A variety of impediments to protecting nursing home residents have been cited. A recent report by the General Accounting Office (USGAO, 2002) cites multiple gaps in protections for residents, including the inadequacies of state registries in tracking employees, inconsistencies by Medicaid Fraud Control Units in investigating abuse and neglect, the failure of local law enforcement to become involved, failure of states to inform consumers how to identify and report abuse, the failure of homes to notify state authorities of abuse allegations, lack of witnesses, and the failure of the Centers for Medicare and Medicaid Service to strengthen resident protections. Other factors that have been cited include employment practices designed to protect workers that compromise accountability such as expunging complaints of abuse from workers files if they can't be proven (Clough, 1999); lack of policies for preventing abuse; low worker pay and morale; lack of training and resources; low status of the work; lack of openness within institutions; lack of training; and poor communication between state agencies that review certificates of need (which must be submitted by providers and approved before they can open a new facility), and those that license and monitor homes, potentially permitting providers who are having trouble with their licensure to open new homes (Menio, 1996). It has further been noted that workers lack models to help them understand the authority, boundaries and intimacy issues posed by this type of work (Clough, 1999).

A variety of options have been proposed to reduce the risk of nursing home abuse:

1. Improve coordination between the various law enforcement, regulatory, protective services, and advocacy organizations that are involved in nursing home care.

2. Improved conditions for workers, through adequate staffing, enhanced communication between direct care and administrative staff, more time to nurture relationships between staff and residents, humane salaries, opportunities for upward mobility, and greater recognition, respect and understanding for the difficult lives many workers lead.

3. Training that focuses on interpersonal caregiving skills, managing difficult resident care situations, problem-solving, cultural issues that affect staff/ resident relationships, conflict reso-lution, stress reduction techniques, infor-mation on dementias, and witnessing and reporting abuse.

4. Improve compliance with federal requirements affecting hiring of abusive nurse aides.

5. Improve reporting through consumer education and stricter enforcement of mandatory reporting.

6. Create support groups for nurse aides.

7. Strengthen resident councils.

8. Improve the screening of prospective staff to focus on applicants' criminal backgrounds, history of substance abuse and domestic violence; their feelings about caring for the elderly; reactions to abusive residents; work ethics; and their ability to manage anger and stress.

9. Create an environment that is conducive to good care.

10. Establish consistent definitions of abuse to improve tracking and research.

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Elder Abuse Listserve Available

Craving more information and details about elder abuse issues and initiatives than a monthly newsletter can provide? Then you want the NCEA listserve!

The elder abuse listserve provides a *free* 24-hour, 7-day-a-week on-line linkage to others working on elder abuse issues. Subscribers "post" (e-mail) a question, announcement, or discussion topic to the listserve, which automatically distributes the message by e-mail to all the other subscribers. Whoever wants to reply can do so. Every subscriber sees all the posts unless two or more subscribers choose to take a particular discussion "off-list" and e-mail privately.

The following professionals working in elder abuse or allied fields are eligible to subscribe to the listserve: adult protective services practitioners and administrators, aging services providers and administrators, educators, health professionals, judges, lawyers, law enforcement officers, prosecutors, policymakers, and researchers.

To subscribe, send an e-mail to the list manager, Lori Stiegel, at lstiegel@staff.abanet.org. A request to subscribe must come from the individual who wishes to subscribe; no one will be subscribed at the request of another person. Your request must include the following information: your name; your e-mail address; your profession and a statement of your interest/expertise in adult protective services/elder abuse; the name of the organization for which you work (if applicable) and its address; and your phone number so that you can be contacted in the event of an e-mail problem.

Reaching the National Center on Elder Abuse (NCEA)

NCEA provides elder abuse information to professionals and the public; offers technical assistance and training to elder abuse agencies and related professionals; conducts short-term research; and assists with elder abuse program and policy development.

It is funded in part by the U.S. Administration on Aging and consists of a partnership of six agencies: the National Association of State Units on Aging (the grantee), the Clearinghouse on Abuse and Neglect of the Elderly, the American Bar Association Commission on Legal Problems of the Elderly, the National Association of Adult Protective Services Administrators, the National Committee for the Prevention of Elder Abuse, and the San Francisco Consortium for Elder Abuse Prevention.

NCEA's website contains many resources and publications to help achieve NCEA's goals. You can find the website at www.elderabusecenter.org. NCEA may also be reached by phone (202/898-2586); fax (202/898-2583); mail (1201 15th Street, N.W., Suite 350, Washington, D.C. 20005); and e-mail (NCEA@nasua.org). ♣

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