Chapter Eight

Patient Abuse and Exploitation

A. Introduction

An 88-year old woman with AD and bipolar disorder was living in a Baltimore City nursing home, bed-bound and requiring assistance with every activity of daily living. On August 12, 1999, a certified nursing assistant (CNA) entered her room to provide incontinence care. The resident was not responsive to the care, became combative, and started yelling racial slurs at the CNA. Losing all self-control under the stress of the situation, the CNA made a fist at the resident, threatened her, made racial remarks, and sprayed incontinent care foam in the resident's face. Ultimately, the CNA was convicted by a jury of second degree assault.

There can be no excuse, no tolerance for what the CNA did. The law rightly imposes criminal sanctions for assaults by caregivers, and this Office vigorously prosecutes cases like this one.

Some would characterize this and similar incidents as aberrations, acts of individual irresponsibility that should not be allowed to obscure the quality of care that so many CNAs and other caregivers provide day after day. Yet, this case and others like it cannot be dismissed as anomalous. Although "precious little [is known] about the prevalence, forms, perpetrators, or victims of abuse and neglect in institutional settings" (Stahl 2000), one

study of nursing home staff found that 10 percent had committed abusive acts themselves, and 36 percent had witnessed physical abuse of residents by other staff members (Pillemer and Moore 1989). Abuse is frequently not reported by its victims, who fear retaliation or who believe that reporting would be futile (Hawes and Kayser-Jones 2003).

There is little population-based information about the occurrence of elder abuse (Bonnie and Wallace 2003, at 74). In noninstitutional settings, reports of elder abuse are thought to fall far short of its actual incidence (Moskowitz 1998). The National Center on Elder Abuse has estimated that, in 1996, there were at least a half-million abused elders in the United States, although "it is difficult to say how many older Americans are abused ..., in large part because surveillance is limited and the problem remains greatly hidden."[1]

One recent literature review confirmed that frail adults over 75 years of age who have a diagnosis of dementia are at heightened risk of mistreatment **(Fulmer 2002).**

Whatever the actual numbers, the harm of abuse includes not only the immediate injury but also a risk of accelerated physical and psychological deterioration; those who are its victims have a significantly poorer survival rate than peers with comparable medical and demographic risk factors (Lachs, Williams, O'Brien et al. 1998). Thus, elder abuse is not only a law enforcement issue but also a major public health concern.

The impairments associated with AD leave its victims especially vulnerable to physical abuse and financial exploitation (Cooney and Mortimer 1995). One recent literature review confirmed that frail adults over 75 years of age who have a diagnosis of dementia are at heightened risk of mistreatment (Fulmer 2002). As the case summarized above illustrates, a person with AD who is unable to understand an intended act of caregiving might feel threatened and react with hostility. If the caregiver loses control, physical retaliation can result. In

addition, a person with a memory problem is at heightened risk of being induced into scam investments or into writing several checks for the same purpose. Consequently, the law should provide special protections for people who are left particularly vulnerable by this disease.

Special reporting obligations apply to alleged abuse against nursing home and assisted living residents, many of whom have AD. Any person who believes that a resident has been abused has a duty to report the incident ....

B. Current Law

1. *Abuse and neglect*

One such law, analogous to the law about the reporting of child abuse and neglect, sets up a protective mechanism for a "vulnerable adult," one who lacks "the physical or mental capacity to provide for the adult's daily needs."[2] This law provides for reporting to Adult Protective Services (APS) of suspected "abuse, neglect, self-neglect, or exploitation."[3] "Abuse" is defined as "physical injury ... as a result of cruel or inhumane treatment or ... a malicious act ..."; "neglect," as "the willful deprivation of ... adequate food, clothing, essential medical treatment or habilitative therapy, shelter, or supervision"; self-neglect," as a vulnerable adult's inability to provide for "the services that are necessary for ... physical and mental well-being"; and "exploitation," as "misuse of the vulnerable adult's funds, property, or person."[4] Upon receiving a report, APS is to carry out an appropriate investigation.[5] Depending on the results, APS is then to render protective services and report suspected criminal activity to the appropriate law enforcement agency.[6]

When a vulnerable adult is abused by a family member or other household caregiver, the abuse may be viewed as a subset of domestic violence, particularly if it reflects a longstanding pattern (Loue 2001). Hence, Maryland's Domestic Violence Law identifies a vulnerable adult as someone entitled to seek judicial relief from abuse.[7]

Maryland law imposes criminal penalties for "knowingly and willfully obtain[ing] by deception, intimidation, or undue influence the property of an individual that the person knows or reasonably should know is a vulnerable adult with the intent to deprive the vulnerable adult of the vulnerable adult's property."
(Criminal Law Article §8-801(b).)

Special reporting obligations apply to alleged abuse against nursing home and assisted living residents, many of whom have AD. Any person who believes that a resident has been abused has a duty to report the incident to a law enforcement agency, the Department of Health and Mental Hygiene, or the Department of Aging.[8] Nursing home employees who fail to do so are themselves subject to a civil penalty.[9]

Reports of abuse or neglect of vulnerable adults in any care setting can lead to criminal enforcement proceedings. A "caregiver" – that is, someone under a contractual duty to care for a vulnerable adult[10] – or other person who has permanent or temporary care or responsibility for the supervision of a vulnerable adult, or a household or family member, who causes abuse or neglect is guilty of a misdemeanor and on conviction is subject to imprisonment for not more than 5 years, a fine of up to $5,000, or both.[11] If the abuse or neglect results in the death of the vulnerable adult, causes serious physical injury, or involves sexual abuse, the penalties are doubled.[12]

In addition, sexual intercourse with a person who is "mentally defective" is rape in the second degree, a felony punishable by imprisonment up to 20 years.[13] Finally, other criminal prohibitions (assault or theft, for example) might also apply to abusive or exploitative acts against people with AD and other vulnerable adults.

Within the Attorney General's Office, the Medicaid Fraud Control Unit has the authority to investigate and prosecute abuse and neglect of vulnerable adults in facilities that receive Medicaid funds. The Criminal Investigations Division also investigates and prosecutes cases involving financial exploitation.

2. *Financial exploitation*

Maryland law imposes criminal penalties for "knowingly and willfully obtain[ing] by deception, intimidation, or undue influence the property of an individual that the person knows or reasonably should know is a vulnerable adult with the intent to deprive the vulnerable adult of the vulnerable adult's property."[14] If the property has a value of $500 or more, the penalty is imprisonment up to 15 years and a fine up to $10,000 .[15] For property of lesser value, the penalty is imprisonment up to 18 months and a fine up to $500.[16]

Under a law enacted in 2000, financial institutions became authorized to report otherwise confidential information about a customer's financial transactions to APS based on the belief "that the customer has been subjected to financial exploitation." To implement this law effectively, this Office joined with the Department of Aging, Department of Human Resources, and Maryland Bankers Association to launch Project SAFE (Stop Adult Financial Exploitation).

Moreover, information suggesting possible financial exploitation has become more readily available to APS and law enforcement agencies. Under a law enacted in 2000, financial institutions became authorized to report otherwise confidential information about a customer's financial transactions to APS based on the belief "that the customer has been subjected to financial exploitation."[17] To implement this law effectively, this Office joined with the Department of Aging, Department of Human Resources, and Maryland Bankers Association to launch Project SAFE (Stop Adult Financial Exploitation). Project SAFE seeks to train bank tellers and supervisors to detect the warning signs of financial exploitation of its vulnerable adult customers. Each financial institution's internal procedures then determine when and who will report the alleged crime to APS.

C. Improved Forensic Evidence

Laws on the books are of diminished value if, as a practical matter, they cannot be enforced effectively. A prosecution is feasible only if evidence is available to prove, beyond a reasonable doubt, that a crime occurred and that the defendant committed it.

The gathering of necessary evidence in abuse cases can be particularly difficult when the victim has AD or another medical condition that compromises the victim's ability to describe the events and, ultimately, testify about them. For example, a pilot study of sexually abused nursing home residents, the majority of whom had AD, indicated that the residents were unable to report abuse directly and that aspects of standard investigative procedure, such as a pelvic examination, were made difficult or impossible by the victims' condition (Burgess, Dowdell, and Prentky 2000).

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This issue is not unique to Maryland, of course. The National Institute of Justice, the research arm of the U.S. Department of Justice, has provided funding for an elder abuse study to the American Bar Association's Commission on Law and Aging. Specifically, the goal of the project is to develop recommendations concerning medical forensic issues. In addition, under another Justice Department grant, the ABA Commission will take the lead in evaluating four elder abuse fatality review teams and disseminating the results in a "promising practices" manual.

In light of these activities and the additional information likely to be forthcoming, we believe it premature to recommend any specific approach for improving the collection of forensic evidence in cases of suspected abuse of people with AD. We shall monitor the ongoing research, however, and coordinate with other interested groups to identify initiatives that may be of practical value.

D. Abuse Prevention Program

As the consensus statement of the Joint Conference on Legal/Ethical Issues in the Progression of Dementia noted, caregivers need help to "balance their own health/safety with the autonomy and dignity of the dementia patient" (Joint Conference on Legal/Ethical Issues in the Progression of Dementia 2001). Among low-wage caregivers in long-term care facilities in particular, "higher job dissatisfaction, burnout, and stress have been found to be associated with abuse of residents" (Loue 2001, at 8).

A primary means of preventing abuse would be the adoption of an effective stress reduction program. At least one such model program was said to reduce conflict with, and abuse of, residents **(Pillemer and Hudson 1993).**

Consequently, a primary means of preventing abuse would be the adoption of an effective stress reduction program. At least one such model program was said to reduce conflict with, and abuse of, residents (Pillemer and Hudson 1993). Another program, aimed at helping CNAs communicate more effectively with residents with dementia, was found to improve the well-being of residents and reduce turnover rates among CNAs (McCallion, Toseland, Lacey et al. 1999).

RECOMMENDATION 8-1: The Department of Aging should convene a meeting of interested parties, including the Office of Health Care Quality, the Department of Human Resources, the Attorney General's Office, and the associations representing long-term care facilities, to begin the process of identifying, pilot testing, and promoting a well-designed and validated abuse prevention program in Maryland nursing homes and assisted living facilities.

When violent incidents occur, police officers are often the first responders. Yet, experts have observed, they "do not have the training to recognize or handle individuals with dementia. There are a growing number of incidents when individuals with dementia are arrested, handcuffed and incarcerated for days due to the lack of alternatives to incarceration to address the needs of this population"
(Spurgeon, Sabatino, Coleman et al. 2001).

E. Risk of Violence by AD Patients

Caregivers and other patients are sometimes the victims of aggressive and assaultive behavior by people with AD. One study of community-dwelling AD patients in Britain found that 18 percent had assaulted their caregivers (Eastley and Wilcock 1997). In a study of Veterans Administration facilities, researchers found that 14.6 percent of facilities reported dementia as the most common diagnostic category of patients who had committed assaults (Lehman, McCormick, and Kizer 1999). Not surprisingly, caregivers who are assaulted by AD patients are more likely to direct abusive behavior back to the patients (Coyne, Reichman, and Berbig 1993; Paveza, Cohen, Eisdorfer et al. 1992). In rare cases, aggressive behavior by people with AD, especially if firearms are at hand, turns deadly (Green and Kellerman 1996; Mendez 1996; Rayel, Land, and T.G. Gutheil 1999; Stein 2003).

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RECOMMENDATION 8-2: The Department of Human Resources should work with police organizations, the Alzheimer's Association, the Family Violence Council, and domestic violence advocacy groups to (i) consider the need for improved services to victims of dementia-related domestic violence and the individuals with AD who have acted violently as a consequence of their disease and (ii) increase

awareness of the risk posed by an AD patient's having access to firearms in the home and the safety measures that might be taken.[18]

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Endnotes

1. http://www.elderabusecenter.org/default.cfm?p=faqs.cfm #seven (accessed September 23, 2003).

2. Family Law Article, § 14-101(q).

3. Family Law Article, § 14-302. Reporting is mandatory for health practitioners, police officers, and human service workers; it is permissive for all other individuals.

4. Family Law Article, § 14-101(b), (f), (l), and (p).

5. Family Law Article, § 14-303.

6. Family Law Article, §§ 14-305 and 14-307.

7. Family Law Article, § 4-501(h)(5) and (l).

8. Health-General Article, § 19-347. This provision applies to reporting of alleged abuse against "a resident of a related institution"; the latter term includes both nursing homes and sited living facilities. Health-General Article, § 19-301(o).

9. Health-General Article, § 19-347(c).

10. Criminal Law Article § 3-603(a)(3).

11. Criminal Law Article § 3-604. The definition of "vulnerable adult" for this criminal penalty is the same as in the Adult Protective Services Law.

12. Criminal Law Article § 3-603(b) and (c).

13. Criminal Law Article § 3-304. A victim is a "mentally defective individual" if a mental disorder "renders the individual substantially incapable of ... appraising the nature of the individual's conduct; ... resisting vaginal intercourse, a sexual act, or sexual contact; or ... communicating unwillingness to submit ...." Criminal Law Article § 3-301(b).

14. Criminal Law Article § 8-801(b).

15. Criminal Law Article § 8-801(c)(1).

16. Criminal Law Article § 8-801(c)(2).

17. Financial Institutions Article, § 1-306 (as enacted by Chapter 407 of the Laws of Maryland 2000).

18. This recommendation parallels that of the Joint Conference on Legal/Ethical Issues in the Progression of Dementia (Joint Conference 2001, at 428-429).