# Survey of State Public Health Departments on Procedures for Reporting Elder Abuse

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**Synopsis**

*All 50 States have passed legislation to protect elderly victims of domestic abuse and neglect. Forty-two States have mandatory reporting laws, with health care providers considered the major professional referral service.*

*This exploratory study of State health departments had as its goals (a) the identification of administrative awareness regarding the State law, (b) the perception of difficulties encountered in the reporting process, and (c) the development of procedures, such as written materials or training curriculum, to assist health personnel with the reporting responsibilities.*

*The study was carried out between April and October 1989. A brief questionnaire was mailed to State health department directors. All 50 States responded, although the respondents represented varying disciplines and staff responsibilities within the health departments or were from agencies that the State had designated to investigate elder abuse. These data should be considered preliminary and suggestive of service needs.*

*The results demonstrated an inverse relationship between awareness of the laws or regulations and specific activities to support the reporting process. Ninety-four percent of respondents were aware of the State law, but only 20 to 28 percent reported the use of written procedures or training materials specifically designed for health personnel. At the same time, approximately one-third were aware of reporting issues that needed to be addressed, including staff unfamiliarity with the regulations, concerns of confidentiality, and uneasiness about reporting in general. Part of the reason for what appears to be inactivity on the part of the State departments of health may lie in the fact that elder abuse reporting laws tend to place implementing authority with human service, aging, or law enforcement agencies rather than with health departments.*

*The variability in reporting and investigative regulations among State elder abuse laws suggests that one national written training program or awareness campaign would be inappropriate. Individual State differences must be recognized for planning and implementation. State health departments, familiar with the law and concerned about the welfare of vulnerable populations, are critically situated to contribute to a strong protective service environment. A major responsibility is to ensure that health care providers are aware of elder abuse as a problem, know its signs, and can effectively carry out reporting obligations. Health departments can be useful facilitators in the development of interdepartmental coordination to address the complex issues of elder abuse.*

ELDER ABUSE is defined as harm experienced by older persons as a result of the actions of others or of themselves. Its various forms include battery, psychological abuse, exploitation, and self-neglect. An estimated 2 million Americans experience elder abuse each year, most of them repeatedly and in multiple forms (*1,2*).

Elder abuse is the latest aspect of family violence to receive broad public recognition. Although there are documented instances throughout American history (*3*), it was not until the late 1970s that elder abuse was discussed in congressional hearings, scientific publications, and the media (*4–8*).

With recognition of the problem came the enactment of State adult protective service and elder abuse reporting laws to identify and treat elder abuse. The majority of the laws were passed during the early 1980s (*9,10*). Today all States have some kind of law for victims of elder abuse, although they differ widely in content (*11,12*). Forty-two

State laws include mandatory reporting (*13*), a provision regarded by some as important for case-finding (*14*).

The usefulness of mandatory reporting rests in the ability of those identified as reporters to recognize elder abuse and make effective referrals for service. Elder abuse protocols help facilitate this. In addition, they acknowledge interagency and interdisciplinary cooperation along with the case management process necessary for handling these complex situations (*15*).

Health providers are major referral sources for elder abuse (*16*). They also are most commonly identified as mandatory reporters in elder abuse reporting laws.

Conventional wisdom suggests that public health officials are the most informed health care providers about laws affecting the safety and welfare of vulnerable populations. It is reasonable to think, therefore, that they are knowledgeable about State elder abuse reporting laws and procedures for their appropriate implementation. To test this assumption, a survey was conducted of officials at State departments of health.

## Methodology

This study was carried out between April and October 1989. A brief two-page questionnaire was sent to the directors of the 50 State departments of public health. A cover letter identified the purposes of the study, requested their cooperation with an immediate response, and promised to provide them with a report of the findings. The letter also identified the staff members of the health departments as "front-line workers who can make a significant contribution to the early identification of abuse situations." Abuse was defined to include physical abuse, neglect, exploitation, and abandonment. The letter and questionnaire requested that respondents supply copies of written materials specifically prepared for health professionals in their State with their completed questionnaires. The formal term "protocols" for written materials was clarified as "written reporting procedures." These terms will be used interchangeably in this report. Two followup mailings to nonrespondents plus five telephone interviews resulted in a response rate of 100 percent.

Since this was a mail questionnaire, the respondents within the health departments who completed it varied considerably in terms of discipline and staff responsibility. In seven cases, the cover letters that accompanied the completed questionnaires indicated the health department had forwarded them to the elder abuse investigating agency for completion. We suspect that this may have been true of some others. Due to the variability in respondents, the information they supplied should be considered as preliminary findings about the topic. The questionnaire, entitled "Survey of State Health Departments on Elder Abuse Reporting Procedures," collected data in the following areas:

- administrative awareness of the State law for reporting elder abuse and neglect,
- procedures developed by the State health departments to assure compliance with the law by health care practitioners, (Questions were asked about the preparation and dissemination of health department protocols for staff members or individual health care practitioners or both and the frequency and content of in-service training sessions.)
- awareness and identification of difficulties encountered by health personnel in reporting situations of abuse and neglect.

Analysis included tabulations of the frequency of responses to closed-ended questions and content analysis of responses to open-ended questions. Related information from correspondence, submitted protocols, and training materials also are incorporated in the findings.

## Results

Table 1 provides a summary of the respondent data for the areas explored in the study.

**Awareness of the law.** Of the 47 responding "Yes," one was in error, defining the professional reporting process as voluntary. Of the three States responding "No" to awareness of the law, all three have laws with mandatory professional reporting requirements. Respondents identified physicians, nurses,and social workers as the major mandatory reporters.

**Procedures—department written protocols.** There were 38 respondents who reported that their health department had no protocol specifically prepared for staff members or related community professionals. More than half (18) of them indicated that it was not the responsibility of their department. The comments of six other State respondents suggest a range of attitudes on the subject:

"Thank you for bringing this to my attention."

"I intend to work on this." "An inter-agency task force is working on this." "It should be done as a joint venture." "Protocols are not necessary, the law is clear." "It's not important which agency does it, but that it is done."

Ten health departments responded that they had department protocols. A review of the materials submitted suggests, however, that these were either for use in reporting abuse in long-term care facilities or brochures and manuals prepared by the responsible investigating agency for general use. Four used the general use brochures and manuals in mailings, in one case to 2,100 community physicians and 165 emergency room physicians. One department had incorporated the regulations in the Community Health Nursing Manual rather than creating a separate document.

**Procedures—department training programs.** There were 14 respondents who indicated that their departments conducted training or awareness campaigns, or both, for physicians and nurses at the time the law was implemented. Six departments maintain ongoing in-service, particularly to clarify legal requirements.

**Reporting difficulties.** Less than one-third of the respondents said they knew of difficulties encountered by health care practitioners in reporting abuse. This group of respondents identified a number of general reporting issues applicable to the total reporting system as well as to the health professional. These were

- lack of clarity with the law—limited familiarity with the requirements, procedures, investigative agencies, and differences between reporting community-based and long-term care facility abuse,
- different definitions of abuse used by health department staff members and abuse investigators,
- lack of adequate number of investigators and timely investigations,
- lack of public awareness,
- uneasiness about reporting — professional denial of abuse occurrence or the unwillingness of families to cooperate, or both, and
- lack of confidentiality for the person reporting abuse.

## Discussion

The findings suggest that State departments of health are aware of elder abuse reporting laws, but it appears that little has been done to further their implementation. More specifically, none of the 50 departments of health surveyed has developed an actual protocol around abuse identification and referral. Sixty-four percent also lacked related in-service training of health care providers, and nearly three-fourths offered no awareness campaign regarding the law.

A contributing factor for what appears as inactivity on the part of the State departments of health may be that responsibilities are diffused. Elder abuse laws generally place implementing authority with human services, aging, or law enforcement agencies rather than with health departments.

Table 2 lists the agencies responsible for abuse investigation. Nearly all States assign this task to social service agencies, although these may have differing titles or authorities. The agency titles clustered under the heading "Social Services" in table 2 include Human Services, Human Resources, Health and Rehabilitation, Social Service and Housing, Social Service and Rehabilitation, Health and Human Services, and Welfare. Fifteen States also list law enforcement agencies as secondary investigators to whom reports can be made.

Nearly half of the health department officials who responded that they lacked a reporting procedures statement for staff members or related health professionals indicated that addressing elder abuse was not their responsibility. Table 2 clearly supports this in terms of ultimate investigating authority.

It is interesting to note that among the one-third of respondents in this study identifying known difficulties in abuse reporting, the majority indicated difficulties that could be corrected through health department initiatives. For example, proto-

Table 1. Results from the survey of 50 State health departments on elder abuse reporting procedures, April–October 1989

| Information areas | Yes | | No | | Don't know | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Awareness of law | 47 | 94 | 3 | 6 | ... | ... |
| Health department has protocols | 10 | 20 | 38 | 76 | 2 | 4 |
| Health department has training | 14 | 28 | 32 | 64 | [1]2 | 4 |
| Awareness of reporting difficulties | 14 | 28 | 34 | 68 | [1]2 | 4 |

[1]In these 2 cases no answer was given.

Table 2. State departments responsible for investigations under elder abuse laws

| Departments | Number of States | Percentage |
|---|---|---|
| Social services | 43 | 86 |
| Ombudsman | 1 | 2 |
| Elder services | 4 | 8 |
| Law enforcement (as a secondary reporting site) | 15 | 30 |

SOURCE: References 9 and 10.

cols would help clarify the law and increase confidence in reporting. Similarly, awareness campaigns would increase public understanding about the problem and may even encourage professional reporting of abuse occurrence. A variety of funding sources are available and have been used locally for these purposes. They include public revenues, foundation grants, and private donations.

The responsibility for developing abuse protocols and initiating awareness campaigns probably cannot rest at the national level. Variability among State elder abuse reporting laws precludes a uniform design that can be implemented. This means that responsibility is localized. Individual State departments of health familiar with the law and concerned about the welfare of vulnerable populations are critically situated to ensure that health providers are aware of elder abuse as a problem, know its signs, and can effectively carry out reporting obligations.

Although the assignment for single agency investigation has been made in each State, the concept of multi-department responsibility for protection of elder abuse victims remains appropriate. Therefore, coordination among State departments in addressing elder abuse is needed but seldom occurs.

One vehicle by which coordination could be accomplished is the ongoing interdepartmental "adult cluster," organized to identify role and responsibility in individual cases that cross departmental jurisdictions. Interdepartmental clusters have proven successful in Ohio and other States for handling complex child abuse situations and deciding service funding arrangements. Coordination also could be enhanced by interdepartmental ad-hoc committees, established to consider topics of broad concern. Ohio likewise used this approach to determine strategies for securing and allocating new State revenues for community-based long-term care, including first time State funding for adult protective services. Among other things, interdepartmental groups like these are useful for developing reporting procedures and staff training. They offer the necessary multiple perspectives and commitments for the accomplishment of these tasks.

Health departments can be useful facilitators in the coordination process. Interested in elder abuse as a public health issue, they are in a better position to be neutral in interdepartmental discussions than agencies charged with report investigation and provision of protective services.

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