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Elder Self-Neglect and Adult Protective Services: Ohio Needs to Do More

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ELDER SELF-NEGLECT AND ADULT PROTECTIVE SERVICES: OHIO NEEDS TO DO MORE

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I. INTRODUCTION

Carlene was found dead at age seventy-nine.[1] She lived in a low income, senior apartment complex in Toledo, Ohio. While many lived around her, no one was required to help Carlene. She had no working light bulbs in her apartment, her toilet seat was broken, and she had no sheets on her bed. Trash was all over the floor and some of it was stained with blood. Carlene was 5-foot-9-inches tall, but her weight had plummeted to eighty-five pounds. She looked ill when neighbors saw her in the laundry room. Her apartment did have a pull cord for emergencies, but she never used it. In fact, Carlene never asked for help, and some think she did not want it. Neighbors tried to alert the front desk, but all the staff could do was call and ask Carlene if she was all right, and Carlene replied that she was fine. Newspapers were also piling up in front of Carlene's door. The front desk called a second time; Carlene did not reply. After a third call went unanswered, apartment staff forced themselves into Carlene's apartment and found out they were too late.

Carlene was unfortunately a victim of self-neglect. The National Center on Elder Abuse (NCEA) has defined self-neglect as "behavior of an elderly person that threatens his/her own health or safety" and is manifested by "refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions."[2] Self-neglect has become the most common form of domestic elder abuse in the United States.[3] While other forms of abuse may receive more publicity, self-neglect is the most reported and substantiated form of elder abuse.[4] Ohio exceeds the national trend in regards to self-neglect reports; self-neglect constituted over half of the reports to Adult

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[1] Caitlin McGlade, *Death Raises Questions on Elderly Self-Neglect*, TOLEDO FREE PRESS, May 4, 2012, http://www.toledofreepress.com/2012/05/04/death-raises-questions-of-elderly-self-neglect/ (providing the narrative of the death of Carlene McNeil who died on March 6, 2012). Unfortunately, Carlene's story is not uncommon across the country, from small towns to large metropolitan centers.

[2] *Major Types of Elder Abuse*, NAT'L CTR. ON ELDER ABUSE, http://ncea.aoa.gov/FAQ/Type_Abuse/ (last visited Jan. 7, 2014). While the NCEA's definition is used here, there is no agreed upon conceptualization of the elderly self-neglect problem. *See infra* Section II(A).

[3] TOSHIO TATARA & LISA M. KUZMESKUS, NAT'L CTR. ON ELDER ABUSE, TYPES OF ELDER ABUSE IN DOMESTIC SETTINGS 2 (1999), *available at* http://www.ncea.aoa.gov/Resources/Publication/ docs/fact1.pdf; PAMELA B. TEASTER ET AL., NAT'L COMM. FOR THE PREVENTION OF ELDER ABUSE & NAT'L ADULT PROTECTIVE SERV. ASS'N, THE 2004 SURVEY OF STATE ADULT PROTECTIVE SERVICES: ABUSE OF ADULTS 60 YEARS OF AGE AND OLDER 8 (2006), *available at* http://vtdigger.org/vtdNewsMachine/wp-content/uploads/2011/08/20110807_survey StateAPS.pdf. There has been some disagreement as to whether or not self-neglect should be considered a type of abuse because there is no identifiable perpetrator, except the elderly person against themselves. *See* GOV'T ACCOUNTABILITY OFFICE, ELDER JUSTICE: STRONGER FEDERAL LEADERSHIP COULD ENHANCE NATIONAL RESPONSE TO ELDER ABUSE (2011), *available at* www.gao.gov/new.items/d11208.pdf. The scope of this paper does not include discussion on whether or not self-neglect is correctly categorized, as this question does not affect the magnitude of the problem for elderly individuals and maintaining quality of life.

[4] TATARA & KUZMESKUS, *supra* note 3, at 25 (stating that according to states' APS agencies self-neglect was investigated (26.7%) and substantiated (37.2%) more than caregiver neglect (23.7%, 20.4%), financial exploitation (20.7%, 14.7%), emotional/psychological abuse (13.6%, 14.8%), physical abuse (12.5%, 10.7%), and sexual abuse (.7%, 1.0%)).

Protective Services (APS) regarding elders.[5] In fact, self-neglect concerns exceeded the combined reports of abuse, neglect, or exploitation in Ohio.[6]

The elder self-neglect problem is exacerbated by the rapid aging of the U.S. population.[7] Currently, 40.4 million people are sixty-five years or older (one in every eight Americans);[8] this is a 15.3% increase since 2000.[9] Aging of the "Baby Boomer" generation is accelerating this growth.[10] By 2030, it is projected that one in five Americans will be sixty-five years or older.[11]

Many elderly individuals receive care in nursing facilities, which have been commonly called nursing homes in the past.[12] According to data collected by the Centers for Medicare and Medicaid, there are approximately 1.4 million nursing facility clients.[13] Ohio ranks fifth in the nation with 79,000 nursing facility clients.[14] At age eighty-five years old or older, twenty-eight percent of Ohioans have had at

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[5] OHIO JOB & FAMILY SERVICES, ADULT PROTECTIVE SERVICES FACT SHEET FOR SFY (2006), *available at* http://jfs.ohio.gov/ocf/APSFACTSHEET2006.pdf. Ohio APS agencies received a total of 7,493 reports of self-neglect. *Id.*

[6] *Id.*

[7] *See* Maria P. Pavlou & Mark S. Lachs, *Self-Neglect in Older Adults: a Primer for Clinicians*, 23 J. GEN. INTERNAL MED. 1841, 1841 (2008) (noting that physicians will increasingly need to deal with self-neglecting patients as the population ages); XinQi Dong, *Decline in Cognitive Function and Risk of Elder Self-Neglect: Finding from the Chicago Health Aging Project*, 58 J. AM. GERIATRICS SOC'Y 2292, 2292 (2010) (stating that self-neglect will become more pervasive as the aging population increases).

[8] ADMIN. ON AGING, A PROFILE OF OLDER AMERICANS: 2011 3 (2011), *available at* http://www.aoa.gov/AoAroot/Aging_Statistics/Profile/2011/2.aspx.

[9] *Id.*

[10] U.S. CENSUS BUREAU, AGE AND SEX COMPOSITION: 2010 2 (2011), *available at* http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf. The Baby Boomer generation is typically considered to be those individuals born between 1946 and 1964. The growth rate of the population aged 45–64 was 31.5%. This rate was significantly higher than those aged 18–44, which was 0.6%, a difference attributable to the aging of the Baby Boomer generation. *Id.*

[11] GRAYSON K. VINCENT & VICTORIA A. VELKOFF, U.S. CENSUS BUREAU, THE OLDER POPULATION IN THE UNITED STATES: 2010 TO 2050 1 (2010), *available at* http://www.aoa.gov/aoaroot/aging_statistics/future_growth/DOCS/p25-1138.pdf.

[12] A confusing array of labels are used to describe facilities in which typically elderly patients receive care. These labels include nursing facility, skilled nursing facility, certified nursing facility, and nursing home. This paper will consistently use the term "nursing facility" to identify facilities in which the elderly receive both long-term and short-term care.

[13] *Total Number of Residents in Certified Nursing Facilities*, KAISER FAMILY FOUND., http://www.statehealthfacts.org/comparemaptable.jsp?ind=408&cat=8&sub=97&yr=138&typ=1&sort=a (last visited Dec. 13, 2012).

[14] *Id.*

least one nursing facility stay.[15] Individuals who are admitted to a nursing facility for short-term rehabilitation, however, average a stay of only twenty-seven days.[16]

Nationally, over the last several decades, the discharge rate from nursing facilities increased from forty-six to ninety-two discharges per hundred beds in 1999.[17] Medicare provides for short-term rehabilitative services in a nursing facility for up to 100 days in a benefit period.[18] The 100 days are not always used consecutively, as the length of stay is based on what is deemed medically necessary.[19] In 2003, of the 169,000 admissions into Ohio nursing facilities, 116,000 were classified as Medicare stays.[20] This figure represents a thirty-seven percent increase from the number of Medicare admissions in 1992.[21]

Despite the high volume of elderly individuals coming in and out of nursing homes, Ohio statutes specifically exclude APS from receiving referrals regarding individuals who are patients in a nursing facility.[22] Ohio APS is mandated to

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[15] CTR. FOR MEDICARE & MEDICAID SERVICES, NURSING HOME DATA COMPENDIUM 33 (2010), *available at* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium_508.pdf.

[16] DAVID C. GRABOWSKI, U.S. DEPT. OF HEALTH & HUMAN SERVICES, POST-ACUTE AND LONG-TERM CARE: A PRIMER ON SERVICES, EXPENDITURES AND PAYMENT METHODS 1 (2010), *available at* http://aspe.hhs.gov/daltcp/reports/2010/paltc.pdf.

[17] FREDERIC H. DECKER, NAT'L CTR. FOR HEALTH STATISTICS, NURSING HOMES, 1977–99: WHAT HAS CHANGED, WHAT HAS NOT? 2 (2005) *available at* http://www.cdc.gov/nchs/data/nnhsd/NursingHomes1977_99.pdf.

[18] CTR. FOR MEDICARE & MEDICAID SERVICES, MEDICARE & YOU 31 (2013), *available at* www.medicare.gov/Pubs/pdf/10050.pdf. A three day hospital stay is required prior to transfer for the nursing facility admission to qualify for Medicare coverage. *Id.* The patient must also require a skilled service such as therapy or intravenous medicine on a daily basis. *Id.* at 31. A benefit period begins from the date a patient is admitted to the hospital. The period ends when sixty consecutive days have passed after discharge without another in-patient stay in a hospital or nursing facility. *Id.* at 133.

[19] *Id.* There is no cap *per se* on the number of nursing facility stays under the Medicare benefit in a given year so long as certain requirements are met: the three day hospital stay is met, there is a medical necessity for care, and the 100 days have not been exhausted. *Id.* at 31. Further, Medicare beneficiaries' benefit period renews after they are not in-patient for sixty consecutive days. In this scenario, individuals can actually exhaust their 100 day nursing facility benefit and potentially still renew the benefit within the same year after returning home. *See id.* at 133. Patients who are frequently admitted and discharge from the same medical facilities are called "frequent flyers"; Medicare has begun to financially penalize healthcare facilities for these patients. *See e.g.*, Jordan Rau et. al., *Metro Area Hospital to Be Hit with Federal Fines for 'Frequent-Flyer' Patients*, KAISER HEALTH NEWS, Aug. 12, 2012, http://www.wnyc.org/articles/wnyc-news/2012/aug/12/metro-area-hospital-be-hit-federal-fines-frequent-flyer-patients/.

[20] SHAHLA A. MEHDIZADEH ET. AL., SCRIPPS GERONTOLOGY CTR., NURSING HOME USE IN OHIO: WHO STAYS, WHO PAYS? (2006), *available at* http://www.scripps.muohio.edu/content/nursing-home-use-ohio-who-stays-who-pays (finding that by six months less than one-third of new nursing facility admissions continued to reside there).

[21] *Id.*

[22] *See* OHIO REV. CODE ANN. § 5101.60(B) (LexisNexis 2011) ("'Adult' means any person sixty years of age or older . . . who is handicapped by the infirmities of aging or who has a

investigate reports of elderly abuse, neglect (both by caregiver and self-inflicted), and exploitation, but cannot do so if the individual is in a nursing facility, even on a short-term basis.[23]

Ohio APS statutes are antiquated, do not reflect the increasingly complex needs of self-neglecting elderly, and need to be changed to decrease the likelihood of significant self-harm or even death, as represented in the story of Carlene. Section II of this paper provides background information on elder self-neglect and APS. Section III discusses why Ohio needs to mandate that APS jurisdiction includes nursing facilities and how the law could be effectively changed. Section IV discusses how APS interventions need to evolve to meet the diverse needs of the growing elderly population; a singular investigative response no longer fits for every client. Instead, development of a *differential* or *alternative response* system will be proposed. Adopted from the field of child protective services, differential response emphasizes a more collaborative approach with the elderly person towards the goal of maintaining community living. Lastly, Section V discusses the financial hurdles that APS will face in making effective changes and possible funding avenues.

II. BACKGROUND

The slow realization that elderly self-neglect is a problem that needs the nation's attention is partly a product of our strong belief in self-determination, especially for adults. A legal scholar noted that "[i]n America, citizens have the inalienable right to make really bad decisions . . . Therefore, it is critical that infringement on an individual's liberty . . . often triggered by self-neglect, does not occur unnecessarily, prematurely, or inappropriately."[24] The tension between an adult person's right to make his own decisions and the responsibility of society to protect the individual from harm has made defining, researching, and addressing self-neglect an arduous and often debated process.

How self-neglect is defined can be a contextual question.[25] An elderly woman who kept a messy home all of her life may not be viewed to be self-neglecting when her house becomes messier.[26] But, if the same woman instead maintained a pristine home but fails to do so in her elder years, then is she self-neglecting when the house becomes cramped with belongings and substantially cluttered?[27] And at what point do her living conditions or her own physical well-being become the concern of society?[28] In defining and discussing self-neglect in this Note, the right to self-

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physical or mental impairment . . . *who resides in an independent living arrangement*. An 'independent living arrangement' is a domicile of a person's own choosing, including, but not limited to, a private home, apartment, trailer, or rooming house. An 'independent living arrangement' . . . *does not include other institutions or facilities licensed by the state* . . .") (emphasis added).

[23] *Id.*

[24] Marie-Therese Connolly, *Elder Self-Neglect and the Justice System: An Essay from an Interdisciplinary Perspective*, 56 J. AM. GERIATRICS SOC'Y (Supp. 2) S244, S247 (2008).

[25] *Id.* at 244.

[26] *See id.*

[27] *See id.*

[28] *Cf. id.* at 245 (explaining that government's power to take action in the context of elder abuse and neglect originates from the authority of police power and *parens patriae*. Under its

determination and liberties for elderly persons are not questioned. Society should not take action in regards to an elderly person because "he or she has offended society's sensibilities or become an irritant, nuisance, or inconvenience to family, friends, or community."[29] Instead, self-neglect should be addressed when the act of *not* assisting or protecting an elderly individual would result in that person being unable to live in the community.[30] The goal of APS, consequently, would not be the infringement on freedom *per se*, but the promotion of continued livelihood at home. The following section reviews various attempts to define self-neglect and observed manifestations of the phenomena.

A. Elderly Self-Neglect: What is Really the Problem?

While approximately eleven states[31] and the federal government[32] have statutorily defined self-neglect, the concept remains elusive.[33] Lack of a standardized definition has hampered research into the issue.[34] There is no standardized and universally accepted definition of the concept in the professional literature.[35] A review of related empirical research studies and scholarly literature garnered approximately thirteen different definitions of elderly self-neglect.[36] While the authors found some similarity amongst the definitions, self-neglect was defined in a wide variety of ways: using the Webster's dictionary definition of "recluse," statutory-based definitions, and using previously-performed research formulations of the concept.[37]

Studies of self-neglect began as early as the 1960's[38] and were referred to as "senile breakdown[s]" by two British researchers.[39] In a 1966 study, these

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police power, the government can regulate citizen conduct under the force of law. Under *parens patriae*, the government steps into the role of parent and protects a citizen who does not have the legal capacity to make informed decisions.).

[29] *Id.* at 247.

[30] *See id.*

[31] *See* LORI STIEGEL & ELLEN KLEM, NAT'L CTR. ON ELDER ABUSE, TYPES OF ABUSE, PROVISIONS AND CITATIONS IN ADULT PROTECTIVE SERVICES LAWS, BY STATE (2007), *available at* http://www.americanbar.org/content/dam/aba/migrated/aging/about/pdfs/Abuse_Types_Statutory_Provisions_by_State_Chart.authcheckdam.pdf; OHIO REV. CODE ANN. § 5101.60(K) (LexisNexis 2013). Ohio integrates the definition of self-neglect under its definition of neglect. "'Neglect' means the failure *of an adult to provide for self* the goods or services necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caretaker to provide such goods and services." O.R.C.A. § 5101.60(K) (emphasis added).

[32] Elder Justice Act of 2009, Pub. L. No. 111-148, § 6702, 124 Stat. 119, 782 (2010).

[33] Pavlou & Lachs, *supra* note 7, at 1842.

[34] Pavlou & Lachs, *supra* note 7, at 1842.

[35] Tova Band-Winterstein et al., *Elder Self Neglect: A Geriatric Syndrome or a Life Course Story?*, 26 J. AGING STUD. 109, 111 (2012).

[36] Maria P. Pavlou & Mark Lachs, *Could Self Neglect in Older Adults be Geriatric Syndrome?*, 54 J. AM. GERIATRICS SOC'Y 831, 833–36 (2006).

[37] *Id.*

[38] Band-Winterstein, *supra* note 35, at 110.

researchers concluded that self-neglect is "an expression of a hostile attitude to and a rejection of the outside community."[40] The early British concept of self-neglect focused on behavioral manifestations such as neglect of the home and first coined the term "Diogenes Syndrome" as a label for the phenomenon.[41] Currently, Diogenes Syndrome is typically used to describe individuals who, in addition to living in squalor, also hoard.[42] North American researchers, on the other hand, used the term "social breakdown syndrome"[43] and focused more on the loss of social functioning.

Within the North American social model, research has further divided self-neglect into two different types—an external and an internal manifestation of the phenomenon.[44] External manifestation involves those characteristics that people commonly associate with self-neglect, such as compulsive hoarding and poor living conditions.[45] On the other hand, there are those whose living conditions are not problematic; their self-neglect is an internal manifestation where they do not take care of themselves and medical issues result.[46]

While this typology may be helpful in understanding self-neglect, it is important to note that the phenomenon is complex in its presentation. Current research points to a diverse spectrum of behaviors with both external and internal manifestations including: filthy personal appearance, gross domestic squalor, hoarding of rubbish, social isolation, refusing medical treatment or a general lack of medical care, poor nutrition, and extreme clutter.[47] Additionally, self-neglect cannot, in some respects, be categorized dichotomously; the question is often not whether it is occurring, but to what degree.[48] This continuum[49] of self-neglect results in the "gray areas"[50] of the

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[39] Duncan Macmillan & Patricia Shaw, *Senile Breakdown in Standards of Personal and Environmental Cleanliness*, 2 BRIT. MED. J. 1032, 1032 (1966).

[40] *Id.* at 1036.

[41] Band-Winterstein, *supra* note 35, at 110.

[42] Carmel Bitondo Dyer et al., *Self-Neglect Among the Elderly: A Model Based on More than 500 Patients Seen by a Geriatric Medicine Team*, 97 AM. J. PUB. HEALTH 1671, 1671 (2007). The use of the Diogenes Syndrome label, however, has caused some confusion in the field as it is also used to describe younger patients with mental illness and unidentifiable diagnoses. *Id.* The condition was named after the Greek philosopher of the same name who advocated self-sufficiency and living a simple life. The term, however, has received criticism for being non-specific and adding confusion to the conversation. Burton Reifler, *Diogenes Syndrome: Of Omelettes and Soufflés*, 44 J. AM. GERIATRICS SOC'Y 1484, 1485 (1996). The term will be present in this paper as it is still used by researchers in the field. *See, e.g.*, Javed Iqbal et al., *A Look at Diogenes Syndrome*, 18 CLINICAL GERIATRICS 45, 45 (2010).

[43] Ernest M. Gruenberg et al., *Identifying Cases of the Social Breakdown Syndrome*, 44 THE MILBANK MEMORIAL FUND QUARTERLY 150, 150 (1960).

[44] *See* Band-Winterstein, *supra* note 35 at 110.

[45] *See* Band-Winterstein, *supra* note 35 at 110.

[46] *See* Band-Winterstein, *supra* note 35 at 110.

[47] *See* Pavlou & Lachs, *supra* note 7, at 1842.

[48] *See Cognitive Function*, *supra* note 7, at 2293.

[49] *See Cognitive Function*, *supra* note 7, at 2293.

[50] Band-Winterstein, *supra* note 35, at 109.

phenomenon; namely, where society must decide at what point it has a duty, and more importantly, the authority, to intervene.[51]

APS workers offer additional perspectives on defining self-neglect. In a study of APS staff persons' working definitions of self-neglect, 56% believed it was an *inability* to self-care, 8% thought it was an *unwillingness*, and 36% thought that it was either one or the other.[52] The National Center on Elder Abuse,[53] however, in defining self-neglect stated it "excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice."[54] Determining an elderly person's capacity, willingness, and ability are central to the efforts to address the self-neglect problem.[55]

Another important perspective to defining self-neglect could come from the elderly individuals themselves. In an Israeli study, sixteen elderly individuals were interviewed and identified by social services as self-neglecting, but cognitively intact and having no diagnosed mental health problems.[56] The researchers found four major themes in how these individuals described their daily lives.[57] One important theme was that the individuals considered their lives, while maybe different from the lives of others, to be normal.[58] Through interactions with society, they were cognizant of others' concern for their condition, but they had generally developed a comfortable routine.[59] Equally important was the theme that these individuals viewed their home environment as their empire in which they perceived value in the personal property around them.[60] These elderly individuals also viewed themselves as having lives of

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[51] *See* Band-Winterstein, *supra* note 35, at 117.

[52] SUZY BRAYE ET AL., SOCIAL CARE INST. FOR EXCELLENCE, SELF-NEGLECT AND ADULT SAFEGUARDING: FINDINGS FROM RESEARCH 7 (2011), *available at* http://www.scie.org.uk/publications/reports/report46.asp.

[53] *See generally* Nat'l Ctr. for Elder Abuse, *What We Do* (Feb. 7, 2012, 12:59 PM), http://www.ncea.aoa.gov/NCEAroot/Main_Site/About/What_We_Do.aspx (The NCEA was first established in 1988 and became a permanent program of the U.S. Administration on Aging in the 1992 amendments of Title II of the Older Americans Act. The NCEA "serves as a national resource center dedicated to the prevention of elder mistreatment.").

[54] *Major Types of Elder Abuse*, *supra* note 2.

[55] BRAYE ET AL, *supra* note 52, at 7; *see also* Aanand D. Naik et al., *Assessing Capacity in Suspected Cases of Self-Neglect*, 63 GERIATRICS 26 (2008) (noting that a central ethical question in determining self-neglect is whether or not the individual can "both make and implement decisions regarding personal needs, health, and safety. . . [or] the capacity for self-care and self-protection").

[56] Band-Winterstein, *supra* note 35, at 111.

[57] Band-Winterstein, *supra* note 35, at 113.

[58] Band-Winterstein, *supra* note 35, at 114.

[59] Band-Winterstein, *supra* note 35, at 114.

[60] Band-Winterstein, *supra* note 35, at 115–16.

unluckiness.[61] Lastly, the interviewees discussed varying levels of acceptance when they were told they were disabled and needed assistance.[62]

While the research field has continued to evolve the concept of self-neglect, some states and now the federal government have statutorily defined the phenomena. In 2010, Congress defined self-neglect with passage of the Elder Justice Act (EJA).[63] The EJA provides a comprehensive but concise conceptualization of the phenomena's causes and effects; researchers should use this definition to standardize what is being measured and to make study results more comparable. The EJA defined self-neglect as "an adult's inability, due to physical or mental impairment, or diminished capacity, to perform essential self-care tasks including: (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health . . . (C) managing one's own financial affairs."[64] While the EJA's definition paints a picture with somewhat of a sterile brush, the clinical images of elder self-neglect can be in fact wide-ranging and strikingly bleak. The following are examples of what has been found in situations of elderly self-neglect: rotten food hidden in cabinets and enough food in the refrigerator to fill five bags;[65] filthy living conditions, including significant insect problems[66] and cramped with refuse, excrement, and bottles of urine;[67] lack of hygiene and personal care, including matted hair,[68] dirt-ingrained skin,[69] and development of pressure ulcers;[70] and extreme forms of hoarding associated with Diogenes Syndrome.[71] In one case, authorities entered a ninety-two year-old man's residence and found the remains of his dead dog stored in a cardboard box.[72]

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[61] Band-Winterstein, *supra* note 35, at 113.

[62] Band-Winterstein, *supra* note 35, at 115.

[63] *See* Lori A. Stiegel, *Elder Justice Act Becomes Law, but Victory is Only Partial*, 31 BIFOCAL Mar.–Apr. 2010, at 1, 1 (stating that the EJA marks the first comprehensive national legislation to address elder abuse); CAROL V. O'SHAUGHNESSY, NAT'L HEALTH POLICY FORUM, THE ELDER JUSTICE ACT: ADDRESSING ELDER ABUSE, NEGLECT, AND EXPLOITATION 1–3 (2010) [*hereinafter* POLICY FORUM], *available at* www.americanbar.org/.../aging/Public Documents/eja_act_art_prtl.pdf (stating that the EJA includes provisions to authorize several significant grant programs for APS and the long term care ombudsman program, establish requirements for reporting crime in nursing facilities, and create advisory bodies within Health and Human Services).

[64] Elder Justice Act (EJA) of 2009, Pub. L. No. 111-148, § 2011(18), 124 Stat. 119, 785 (2010).

[65] Kevin W. Greve et al., *Personality Disorder Masquerading as Dementia: A Case of Apparent Diogenes Syndrome*, 19 INT. J. GERIATRIC PSYCHIATRY 701, 704 (2004).

[66] *Id.*

[67] Iqbal, *supra* note 42, at 45.

[68] Iqbal, *supra* note 42, at 45.

[69] Iqbal, *supra* note 42, at 45.

[70] Naik et al, *supra* note 55, at 24.

[71] Dyer et al, *supra* note 42.

[72] Iqbal, *supra* note 42, at 45.

While there is some debate on the conceptualization of self-neglect, there is little question that the problem is associated with negative effects on the elderly individual. A large study involving over 6,000 participants, as part of the Chicago Health and Aging Project, found that reported and confirmed self-neglect is independently associated with a risk of hospitalization.[73] In addition, as the severity of the self-neglect increased, the risk of hospitalization was higher.[74] The researcher concluded that it is important for social service and healthcare professionals to identify those individuals who are at risk of self-neglect.[75] Earlier intervention could decrease the likelihood that the self-neglect will become more severe and result in hospitalization.[76] This recommendation is central to the argument presented in this paper: the sooner APS becomes involved with an at-risk individual, the greater the chances of success at home.

Like Carlene,[77] another significant concern is that self-neglect is associated with a substantially increased risk of mortality.[78] A 2009 study, another associated with the Chicago Health and Aging Project, showed that after one year of reported elderly self-neglect, the mortality risk for the self-neglecting individual was almost six times higher than that of an individual not identified as self-neglecting.[79] Self-neglecting elderly also had increased mortality risks for cardiovascular, pulmonary, neuropsychiatric, endocrine or metabolic, and neoplasm related death.[80] Forty-six percent of the elderly individuals who excessively hoard (i.e., have Diogenes Syndrome) as part of their self-neglect die within five years.[81] The importance of adequately addressing the self-neglect issue is apparent by its impact on the elderly person's general medical health, increased risk of mortality, and continued ability to remain in the community setting.

B. Elder-Self Neglect Causes

The research into the causal factors for elder self-neglect is complicated by three factors. First, as previously discussed, self-neglect has been conceptualized into different forms and researched based on those various perspectives.[82] Second, there is the question of whether or not factors often associated with self-neglect, such as a

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[73] XinQi Dong et al., *Elder Self-Neglect and Hospitalization: Findings from the Chicago Health and Aging Project*, 60 J. AM. GERIATRICS SOC'Y 202, 202 (2012). The author notes that the Chicago Health and Aging Project is a longitudinal, population-based, epidemiological study of residents aged sixty-five years or older. *Id.*

[74] *Id.* at 207.

[75] *Id.*

[76] *Id.*

[77] *See supra* Section I.

[78] XinQi Dong et al., *Elder Self-Neglect and Abuse and Mortality Risk in a Community-Dwelling Population*, 302 J. AM. MED. ASS'N 517, 523 (2009).

[79] *Id.* at 520.

[80] *Id.* at 522.

[81] Iqbal, *supra* note 42, at 46.

[82] *See supra* Section II(A).

decline in cognitive function, are a *cause* or an *outcome* of the neglect.[83] Third, researchers only recently developed a scale to specifically distinguish self-neglecters from those who do not self-neglect.[84] This tool, called the Self-Neglect Severity Scale (SSS), assesses domains of self-neglect, which are: hygiene, functioning, and environment.[85] The scale has shown promisingly reliable results and could be a useful tool for practitioners.[86] The SSS stands in contrast to the Mini-Mental Status Exam (MMSE) which has been a long-standing cognitive screening test used by healthcare professionals.[87] The statistical significance of the MMSE score in assessing self-neglect, however, has been questioned.[88]

Despite these hurdles, elderly self-neglect research is advancing, but remains limited compared to other fields.[89] In addition, researchers have proposed a myriad of factors associated with increased risk of self-neglect. Dr. Pavlou and Dr. Lachs of Weill Cornell Medical College noted seventeen potential risk factor of elder self-neglect.[90] But, the correlation between self-neglect and some of these factors has not been consistently found, and the research is at times contradictory.[91]

Personality traits have been thought to be closely associated with risk of developing self-neglect later in life.[92] A recent large study, however, concluded that no significant association existed between personality traits and elder self-neglect.[93]

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[83] *Cognitive Function*, *supra* note 7, at 2297–98.

[84] Gregory Paveza, *Elder Self-Neglect: A Discussion of a Social Typology*, 54 J. AM. GERIATRICS SOC'Y S271, S271 (2008).

[85] *Id.* at S273.

[86] *Id.* at S272.

[87] *See Cognitive Function*, *supra* note 7, at 2297.

[88] *See Cognitive Function*, *supra* note 7, at 2297 (finding no statistically significant association between the MMSE and elder self-neglect). Dong discusses concern that practitioners who use the MMSE as the sole means of screening and detecting for self-neglect should consider more comprehensive testing. *Cognitive Function*, *supra* note 7, at 2297.

[89] *See* Carmel Bitondo Dyer et al., *Future Research: A Prospective Longitudinal Study of Elder Self-Neglect*, 56 J. AM. GERIATRIC SOC'Y. 261 (2008); *see* Band-Winterstein, *supra* note 35, at 109.

[90] Pavlou & Lachs, *supra* note 7, at 1843. The authors propose several risk factors and correlates of elderly self-neglect: Medical co-morbidity, dementia, depression, alcoholism, anxiety disorders and phobias, schizophrenia and delusional disorders, obsessive-compulsive disorder, personality disorders and lifelong personality traits, other mental illness, metabolic and other organic disorders that can influence cognition and behaviors, sensory impairments, physical impairments, social isolation, low education, poverty, adverse life events, and pride in independence.

[91] *See* discussion *infra* pp. 18–19.

[92] *See* XinQi Dong et al., *Association of Personality Traits with Elder Self-Neglect in a Community Dwelling Population*, 19 AM. J. GERIATRIC PSYCHIATRY 743 (2011).

[93] *Id.* at 749. The study involved over 9,000 elderly individuals; 1,800 of them were identified as self-neglecting. *Id.* The personality traits considered in this study were neuroticism, extraversion, rigidity, and information processing. *Id.* Neuroticism was defined as the disposition to experience psychological stress; extraversion, the tendency to be outgoing, energetic, and optimistic; information processing, the individual's preferred

Additionally, this same study found no correlation between the severity of self-neglect and the personality traits.[94] Experience of field clinicians, however, supports the notion that elderly self-neglecters have a past history of being reclusive and eccentric.[95] Additionally, mental health problems are frequently associated with self-neglect.[96] Research indicates, however, that over half of the individuals diagnosed with Diogenes Syndrome have no psychiatric history.[97]

Cognitive deficit is another factor that has been under recent study for its association with self-neglect. Dementia has been well-established as a risk factor in longitudinal studies.[98] While self-neglect and dementia are sometimes closely associated, in other cases there is no cognitive deficit.[99] Further, research has shown that a decline in *global* cognitive function is not independently associated with self-neglect, but decline in *executive* cognitive function is correlated with an increased risk.[100]

Other factors have been correlated with the risk of elderly self-neglect. One of the least disputed is poor social support; elderly self-neglecting individuals are likely to lack contact with family, friends, and religious organizations.[101] There is also a higher prevalence of self-neglect among African-Americans and among those with lower levels of education and income.[102] Still, others have postulated that self-neglect is mostly effectuated by a lack of financial resources, inadequate healthcare,

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approach to learning and using information; rigidity, the lack of active imagination and intellectual curiosity. *Id.* The researchers concluded that, while initially finding a correlation between personality traits and self-neglect, this association disappeared after considering potential confounding variables. *Id.* They recommend that practitioners consider other factors in assessing self-neglect, as the problem may not be solely due to a specific personality trait. *Id.*

[94] *Id.* at 743.

[95] Colm Cooney & Walid Hamid, *Review: Diogenes Syndrome*, 24.5 AGE & AGING 451 (1995), *available at* Academic OneFile.

[96] *E.g.*, Dyer et al, *supra* note 42, at 1672. In this study, mental disorders were second only to cardiovascular disease in the patients diagnosed with self-neglect.

[97] Greve et al, *supra* note 64, at 703–04 (stating that associated psychiatric disorders include obsessive-compulsive disorder, paranoid schizophrenia, and depression).

[98] Pavlou & Lachs, *supra* note 7, at 1842.

[99] Greve et al, *supra* note 64, at 704. On the contrary, studies have found that most of those self-neglecting "have average or above-average intelligence." Greve et al, *supra* note 64, at 704.

[100] *Cognitive Function*, *supra* note 7, at 2296–97 (explaining executive function refers to the brain's frontal lobe functions including planning, initiation, organization, self-awareness, and execution of tasks).

[101] Jason Burnett et al., *Social Networks: A Profile of the Elderly Who Self-Neglect*, 18 J. ELDER ABUSE & NEGLECT 35, 36 (2006).

[102] XinQi Dong et al., *Prevalence of Self-Neglect Across Gender, Race, and Socioeconomic Status: Findings from the Chicago Health and Aging Project*, 58 GERONTOLOGY 258, 258 (2011).

and social support programs.[103] One commentator argued it is likely the poor perception of nursing facilities that causes the elderly to remain in self-neglecting environments.[104] There have also been several attempts to formulate a theoretical framework or model from which to conceptualize the various proposed risk factors of elder self-neglect.[105]

The uncertainty in defining self-neglect and the existence of multi-factorial risks highlight the complexities of this problem. A recent uptick in self-neglect research, however, indicates a better awareness of this growing problem. The growing wealth of understanding regarding this at-risk population should prompt the APS field to review its current interventions and impact on these individuals.

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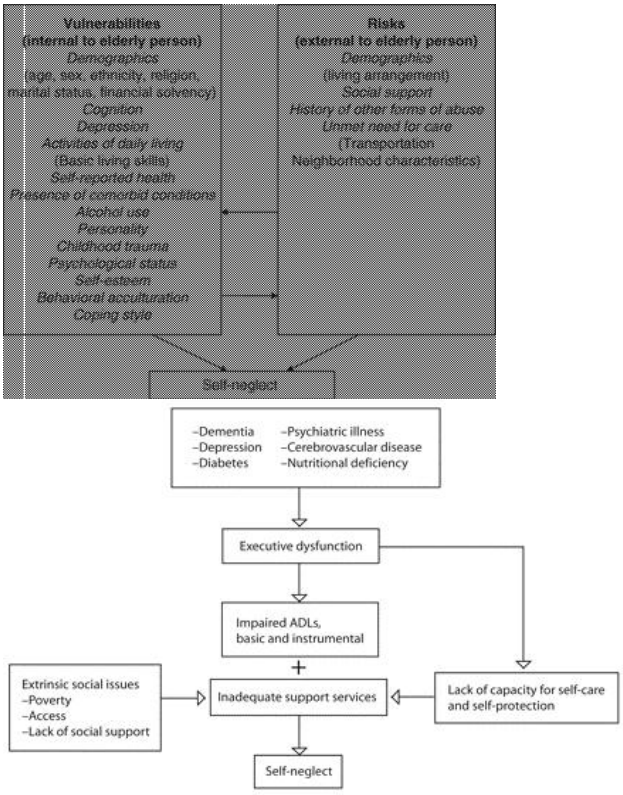
[103] Namkee G. Choi et al., *Self-Neglect and Neglect of Vulnerable Older Adults: Reexamination of Etiology*, 52 J. GERONTOLOGICAL SOC. WORK 171, 184 (2009).

[104] Connolly, *supra* note 24, at 246.

[105] *E.g.*, Dyer et al, *supra* note 42 at 1675; Paveza, *supra* note 84, at S274. Both theoretical framework are respectively presented below:



C. Adult Protective Services

The singular purpose of APS is the protection of the elderly.[106] APS advocates for the well-being of the elderly who may be in danger of mistreatment or neglect and have no one to assist them.[107] The NCEA states the guiding value of APS is that "every action taken by [APS] must balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination."[108]

Nationally, efforts to protect the elderly began in 1950 when President Harry Truman held the first National Conference on Aging.[109] Over twenty years passed before Congress authorized APS funds under Title XX of the Social Security Act in 1974.[110] Thereafter, there has been a patchwork of federal legislation and funding with the goal of improving protection of the elderly, including the recent passage of the EJA in 2010.[111]

Ohio passed its own APS statutes in 1981,[112] and the Ohio Department of Job and Family Services (ODJFS) is designated to administer the program.[113] Each county department of job and family services investigates reports of adults suffering from abuse, neglect, or exploitation.[114] If an investigation confirms that a person is in need of assistance, consent must be obtained from the individual for APS to begin.[115] If

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[106] Margart H. Kreiner & Deanna L. Durbin, OHIO ELDER LAW § 19:16 (Westlaw 2013), *available at* Westlaw OHELD.

[107] *Ethical Principles and Best Practice Guidelines, Adult Protective Services*, NAT'L CTR. ON ELDER ABUSE, http://www.ncea.aoa.gov/Stop_Abuse/Partners/APS/Guidelines.aspx (last visited Jan. 7, 2014).

[108] *Id.*

[109] Brian W. Lindberg et al., *Bringing National Action to a National Disgrace: The History of the Elder Justice Act*, 7 NAELA J. 105, 107 (2011).

[110] Joanne Marlatt Otto, *The Role of Adult Protective Services in Addressing Abuse*, 24 GENERATIONS 33, 33 (2000). Under Title XX, states were allowed to use Social Services Block Grant funds for adult and child protective services. *Id.*

[111] *See* Lindberg et al., *supra* note 109, at 109. Prior to the EJA, federal attempts to pass elder protection laws had generally failed and states developed adult protection statutes on their own. Lindberg et al, *supra* note 109, at 109. When Congress reauthorized the 1965 Older Americans Act in 1987, it defined elder abuse and provided for Elder Abuse Prevention Services. Congress, however, unfortunately did not fund the program. Lindberg et al, *supra* note 109, at 109. Poor funding continued for several decades as Social Services Block Grants were on the decline. Lindberg et al, *supra* note 109, at 109. When Congress did authorize separate funding for elder abuse in 1990, it was only $2.9 million for all fifty states. Lindberg et al, *supra* note 109, at 109.

[112] OHIO REV. CODE ANN. § 5101.60-5101.71 (LexisNexis 2013).

[113] *Adult Protective Services Fact Sheet*, OHIO DEP'T OF JOBS & FAMILY SERV. (Oct. 2013), http://jfs.ohio.gov/factsheets/APS_FactSheet.pdf.

[114] OHIO REV. CODE ANN. § 5101.62 (LexisNexis 2013); *see also* BUREAU OF FAMILY SERVICES, OHIO DEP'T OF JOBS & FAMILY SERVICES, THE ADULT PROTECTIVE SERVICES INTAKE SCREENING TOOL AND GUIDELINES 5 (2010), *available at* http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/JFS07130FCAGUIDE.PDF.

[115] OHIO REV. CODE ANN. § 5101.64 (LexisNexis 2011). The statute does not specify if consent is written or verbal.

consent is withdrawn, services are terminated.[116] On the other hand, if an individual is incapacitated and there is no other authorized person to give consent the court can issue an order requiring the provision of protective services and in some cases order placement in a respective care setting.[117] Protective services can include case work, medical care, mental health, legal consultation, fiscal management, home health care, housing-related assistance, guardianship, and the provision of food and clothing.[118] APS, however, cannot investigate allegations of self-neglect or initiate supportive services if the elderly person is in a nursing facility.[119] The following section discusses why other agencies cannot adequately address the needs of this population and proposes changes to Ohio APS jurisdiction after review of the laws in Minnesota and Mississippi.

III. THE NEED FOR REMOVING APS JURISDICTIONAL RESTRICTIONS

The current structure of elderly advocacy is inadequate for individuals who are in a nursing facility but will eventually return to living in the community. Currently, concerns over abuse and neglect in nursing facilities are investigated by the Ohio Department of Health and the Long Term Care Ombudsman.[120] These organizations, however, either have no jurisdiction in the home setting or their community advocacy and investigative duties are inadequate.[121] These entities cannot address the problems facing the elderly person who is expecting to return home after a nursing facility and who is likely to self-neglect. The following section explains how the Department of Health and the Ombudsman program fall short in addressing the needs of the self-neglecting elderly and how Ohio APS jurisdiction should be changed in response to this deficit.

A. The Ohio Department of Health

The Ohio Department of Health is mandated to license nursing facilities[122] in the state, regulate their operations,[123] cite any deficiencies,[124] order compliance, and issue sanctions.[125] Under the regulatory duty, the Department of Health investigates allegations of abuse or neglect of nursing facility residents.[126] Neglect, as defined by

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[116] *Id.*

[117] OHIO REV. CODE ANN. §§ 5101.65, 5101.67 (LexisNexis 2011).

[118] OHIO REV. CODE ANN. § 5101.60(N) (LexisNexis 2013).

[119] *See* OHIO REV. CODE ANN. § 5101.60(B) (LexisNexis 2011).

[120] *See* OHIO REV. CODE ANN. § 3721.23; § 173.19 (LexisNexis 2011).

[121] *See infra* Part III(A)–(B) (discussing that the Ohio Department of Health does not have jurisdiction in the private home setting, and the Ohio Ombudsman Program only addresses complaints by clients about providers).

[122] OHIO ADMIN. CODE 3701-17-03 (2012).

[123] OHIO REV. CODE ANN. § 3721.04(A) (LexisNexis 2011).

[124] OHIO ADMIN. CODE 3701-61-06(C) (2012) (referring to deficiencies designated under sections 5111.35-.62 of the Ohio Revised Code); OHIO REV. CODE ANN. § 5111.35–.62.

[125] OHIO ADMIN. CODE 3701-61-06(A) (2012).

[126] OHIO REV. CODE ANN. § 3721.22 (LexisNexis 2011). The Ohio Revised Code and Ohio Administrative Code use the term "resident" which may cause some confusion. Resident

statue, however, excludes the concept of *self*-neglect.[127] The Ohio Revised Code, under these nursing facility provisions, states that "'[n]eglect' means recklessly *failing to provide* a resident with any treatment, care, goods, or service necessary to maintain the health or safety of the resident . . . ."[128] Self-neglect is neither defined nor considered within the statutes and rules for the nursing facility setting.[129]

State statutory and regulatory requirements are oriented to address a facility's responsibility to protect the patient from abuse or neglect by others. There are two major issues with this singular focus. First, the negative effects of a patient's actual self-neglect, or risk thereof, is the responsibility of the nursing facility. The only exception is "at the resident's option, to receive only treatment by spiritual means through prayer in accordance with the tenants of a recognized religious denomination."[130] If a patient, whose capacity is not challenged otherwise, chooses to self-neglect for any *non*-religious reasons, the nursing facility remains responsible for serious harm that comes to that patient. If that patient is then discharged and goes home, however, this "responsibility" somehow shifts back to the patient.

Secondly, the nursing facility is required to discharge patients "in an orderly, dignified, and safe manner."[131] This requirement, however, is vague and does not specifically address scenarios where self-neglect is suspected to have occurred or is likely to occur after the patient returns home.[132] Under this requirement, sufficient discharge plans can be in place, but this does not prevent nor address the possibility that the patient will return to a life of self-neglect after returning home. While the Ohio Department of Health's jurisdiction is restricted to those facilities which it has licensed, the Long Term Care Ombudsman's purview does not face this limitation. The Ombudsman is similarly focused, however, on the provider and substandard care by others.

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would imply a long-term or indefinite length of stay. However, under the Ohio Revised Code the term includes a "resident, *patient*, former resident or *patient* . . . ." *Id.* at § 3721.21(F) (emphasis added); *see supra* Part I (noting that discharge rates have doubled and many stays in nursing facility are now considered short-term).

[127] OHIO REV. CODE ANN. § 3721.21(D) (LexisNexis 2011).

[128] *Id.* (emphasis added).

[129] *See generally* OHIO REV. CODE ANN. §§ 3721.21(D) –.34 (LexisNexis 2011); OHIO ADMIN. CODE 3701-17-01 to -17-68, 3701-61, 3701-64-01 to -64-05 (2012).

[130] OHIO REV. CODE ANN. § 3721.21(D).

[131] OHIO ADMIN. CODE 3701-17-14(G).

[132] For approximately twelve years, the author of this Note was a social worker for a nursing facility. In his experience, some patients would either exhibit indicators of prior self-neglect or were determined to be at a higher risk for self-neglect after discharge. Effective intervention, however, was limited if the person's capacity was not in question and if there was not unequivocal evidence of prior self-care problems at home. In addition, APS could not accept a referral while the patient was still in the facility.

B. Long Term Care Ombudsman Program

The Long Term Care Ombudsman program of Ohio is not restricted to the nursing facility in investigating complaints by consumers.[133] Instead, its duty is extended to community based long-term care services,[134] public agencies, or health and social services agencies that may adversely affect the rights of the consumer.[135] The mission of the Ombudsman program is to "seek resolution of problems and advocate for the rights of home care consumers and residents of long-term care facilities with the goal of enhancing the quality of life and care of consumers."[136] Ombudspersons are called upon to investigate complaints related to the health, safety, welfare, or civil rights of a resident or recipient or any violation of a nursing facility resident's rights.[137] After an investigation, the ombudsperson can attempt to resolve the complaint through various means, including consumer empowerment, negotiation, mediation, referral to other agencies, and developing an action plan in conjunction with the client.[138]

On its face, the fact that the Ombudsman Program's investigative and advocacy duties are not restricted to the nursing facility setting would appear to ameliorate the problem of addressing elderly self-neglect in the community. There are several limiting factors, however, that minimize the program's effectiveness with this population. First, the ombudsperson only acts with the consent of the client or the

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[133] OHIO OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN, REPORT OF THE STATE OMBUDSMAN FED. FISCAL YEAR 2010 2, 4 (2010) [hereinafter OMBUDSMAN REPORT], *available at* http://www.ltcombudsman.org/sites/default/files/ombudsmen-support/programpromotion/SLTCO%20Annual%20Report%20FFY%202010%20FINAL%20for%20website.pdf. The (federal) Long-Term Care Ombudsman program was established in 1978 under the Older Americans Act (OAA) and is administered by the Administration on Aging within the Department of Health and Human Services. *See* KIRSTEN J. COLELLO, CONG. RESEARCH SERV., RS21297, OLDER AMERICANS ACT: LONG-TERM CARE OMBUDSMAN PROGRAM 1 n.1 (2009), *available at* http://aging.senate.gov/crs/aging12.pdf. In 1992 an OAA amendment authorized vulnerable elder rights protection activities. *See* KIRSTEN J. COLELLO, CONG. RESEARCH SERV., RS21297, OLDER AMERICANS ACT: LONG-TERM CARE OMBUDSMAN PROGRAM 1 (2009), *available at* http://aging.senate.gov/crs/aging12.pdf. Ohio is one of only twelve states which extends ombudsman services to community-based long-term services. NAT'L OMBUDSMAN RESOURCE CTR., NAT'L ASS'N OF STATES UNITED FOR AGING & DISABILITIES, STATE LONG-TERM CARE OMBUDSMAN PROGRAM, 9 (2011), *available at* http://www.nasuad.org/documentation/nasuad_materials/NASUAD%20Ombudsman%20Report%20final.pdf.

[134] OHIO REV. CODE ANN. § 173.14(C) (LexisNexis 2011) (listing community-based, long-term care services as including case management; home health care; homemaker services; chore services; respite care; adult day care; home-delivered meals; personal care, physical, occupational, speech therapy; transportation; and any other health and social services provided to persons that allow them to retain their independence in their own homes or in community care settings).

[135] OHIO ADMIN. CODE 173-14-16 (2012).

[136] OMBUDSMAN REPORT, *supra* note 133, at 4.

[137] OHIO REV. CODE ANN. § 173.19(A)(1), (2) (LexisNexis 2011).

[138] OHIO ADMIN. CODE 173-14-16(C) (2012).

client's legal representative.[139] For the self-neglecting elderly person, outside help is often unwelcomed.[140] In addition, they typically do not have a strong support system including a legal representative. Lack of consent could be a significant barrier.

In addition, the nature of a referral to the Ombudsman Program does not address the problem of elderly self-neglect. The ombudsperson investigates a complaint registered about a provider that is servicing the elderly person.[141] Again, the focus is on the action or inaction of a provider of long term care, governmental agency, or social services agency.[142] Their duty does not cover *per se* the elderly person who is self-neglecting in absence of outside services. Further, data for the Ohio Ombudsman Program shows that a large majority of complaints registered are against nursing facilities (85%) and only 3% are regarding home and community based care.[143] The Ombudsman program is, practically speaking, addressing primarily facility-based issues and much less those of the community setting.[144] The APS jurisdiction restriction should be removed because neither the Ombudsman Program nor the Ohio Department of Health can effectively intervene in cases where the elderly person is at a high risk of self-neglect upon discharge from a nursing facility.

C. Removing the APS Jurisdictional Restriction

The investigative and advocacy gap that currently exists for self-neglecting elderly upon discharge from nursing facilities needs to be filled. Ohio law should be changed to reflect the more transitory nature of the elderly through the health care system. The modern reality is that most elderly are not living permanently in nursing facilities, but instead they are receiving rehabilitation and/or skilled nursing services and then returning to their homes. Ohio law should reflect this shift in the elderly population by removing the APS restriction in nursing facilities [145] and affirmatively establishing APS jurisdiction in this setting.

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[139] OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN, OHIO DEP'T OF AGING, PROGRAM PROFILE 1 (2011), *available at* http://aging.ohio.gov/resources/publications/profile_ombudsman.pdf; *see* OHIO ADMIN. CODE 173-14-16(B)(2)(a) (2012). The statute does not state whether consent can be written, oral, or implied. OHIO ADMIN. CODE 173-14-16(B)(2)(a) (2012).

[140] *See supra* Section II(A).

[141] *See* OHIO REV. CODE ANN. § 173.19 (LexisNexis 2011).

[142] *Id.*

[143] OMBUDSMAN REPORT, *supra* note 133, at 16 illus. Complaints Received.

[144] *But see* OMBUDSMAN REPORT, *supra* note 133, at 24 (explaining that the Ohio Ombudsman program contracted with the Ohio Department of Jobs and Family Services to provide transition coordinator services under the HOME choice program. HOME Choice provides funding and resources for nursing facility residents who want to return to the community. In fiscal year 2010, however, the Ombudsman program assisted only 246 residents in this transition state-wide, which averages to approximately 3 residents per county).

[145] *See* OHIO REV. CODE ANN. § 5101.60(B) (LexisNexis 2011); *see also* MEHDIZADEH ET AL., *supra* note 20; *see also supra* text accompanying note 22.

Ohio is one of only seven states that affirmatively excludes APS jurisdiction in nursing facilities.[146] On the other hand, seven states affirmatively assert APS nursing facility jurisdiction, including: Arkansas, Maine, Minnesota, Mississippi, South Carolina, Vermont and Washington.[147] The remaining states do not use living situation as a threshold eligibility factor in determining APS involvement.[148] The fact that the majority of the country does not use living situation as an eligibility factor is not dispositive in the argument for Ohio to change its laws in this area, but it is certainly persuasive. Ohio should consider elements of Minnesota and Mississippi law in improving APS law to affirmatively assert nursing facility APS jurisdiction.[149]

1. Minnesota Law

The state of Minnesota passed its Vulnerable Adult Protection Act in 1980,[150] in which the legislature stated its public policy was "to protect adults who, because of physical or mental disability or *dependency on institutional services*, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based

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[146] *See* Lori Stiegel & Ellen Klem, *Types of Abuse, Threshold Eligibility for Adult Protective Services: Criteria, Provisions and Citations in Adult Protective Services Laws, by State*, A.B.A. 21–22 (2007), http://www.americanbar.org/content/dam/aba/migrated/aging/about/pdfs/Statutory_Provisions_for_Threshold_Eligibility_Criteria_for_APS.authcheckdam.pdf (listing the other six states as: Georgia, Illinois, Kansas, Missouri, New Jersey, and Oregon).

[147] *Id.*

[148] *Id.*

[149] Mississippi and Minnesota are discussed here as both states' statutes contain elements that are congruent with the proposed changes of Ohio APS law as discussed in this paper. Other states' statutes provide APS nursing facility jurisdiction, but limit APS's effectiveness in some way. For example, Arkansas gives APS jurisdiction over endangered persons, which is defined as a resident of a *long-term care facility*, but who is found to be in a situation that poses an *imminent risk* to that resident. ARK. CODE. ANN. § 12-12-1703(5)(B)(i) (LexisNexis 2013). An elderly patient in a nursing facility, on a short-term basis, may not face imminent risk at the time they are receiving care and support from facility staff. This Arkansas provision, consequently, would preclude APS involvement despite the scenario where the nursing facility social worker has a strong suspicion of self-neglect prior to hospitalization that will likely resume when the patient is discharged home. Vermont's statute is another example where the statue falls short. In Vermont, APS has jurisdiction over vulnerable adults, which includes residents of nursing homes. VT. STAT. ANN. tit. 33, § 6903(a)(1) (2012). Vermont, however, has not yet recognized self-neglect under its adult protective laws. *See* VT. STAT. ANN. tit. 33, § 6902 (2012). As some states, like Ohio, have integrated self-neglect into their definitions of neglect, Vermont specifically states that "'[n]eglect' means purposeful or reckless failure or omission by a *caregiver*. . . ." VT. STAT. ANN. tit. 33, § 6902(7) (2012) (emphasis added). Vermont is one of only eight states that have yet to recognize self-neglect under protective service laws. *See* LORI STIEGEL & ELLEN KLEM, *Types of Abuse: Comparison Chart of Provisions in Adult Protective Services Laws, by State*, A.B.A. (2007), http://www.americanbar.org/content/dam/aba/migrated/aging/about/pdfs/Abuse_Types_by_State_and_Category_Chart.authcheckdam.pdf.

[150] Eric S. Janus, *The Minnesota Vulnerable Adults Protection Act: Analysis*, VULNERABLE ADULT JUST. PROJECT 1, 1 (Nov. 1991), http://mnvac.pbworks.com/f/The+Janus+Report.pdf.

services . . . ."[151] Minnesota statutory construction is significant here because it presents a two-prong approach to defining a vulnerable adult and one who is eligible for APS in the state.

Minnesota can provide APS to an individual if they meet the definition of a vulnerable adult.[152] Minnesota has two alternate tests of vulnerability—one could be called the "categorical component," and the other, the "functional component."[153] Under the categorical test, vulnerability is met if the adult is dependent on institutional services.[154] The rationale for this arm of the law is to have some certainty as to membership in the class of vulnerable adults by basing it on an objective fact.[155] The objective fact is that the person is dependent on institutional services.

Procedurally, abuse or neglect concerns are called into a "common entry point" in the respective county that is operated twenty-four hours a day/seven days a week by the Board of County Commissioners.[156] While Minnesota law does not specifically define self-neglect, the definition of neglect includes:

> The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical and mental capacity or dysfunction of the vulnerable adult.[157]

In the training manual for investigators and adult protection workers, the Minnesota Department of Human Services affirmatively states that "[s]elf-neglect is considered a category of maltreatment."[158] In addition, the local social services agency investigates *all* complaints alleging that a vulnerable adult has been abused or neglected in the respective county.[159]

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[151] MINN. STAT. § 626.557 subdiv. 1 (2012) (emphasis added).

[152] MINN. STAT. § 626.557.

[153] Janus, *supra* note 150, at 3, 6. To meet the functional test, four elements are required: "[A] person must be (1) unable or unlikely to (2) report abuse or neglect (3) without assistance (4) because of impairment or mental or physical function or emotional status." Janus, *supra* note 150, at 6 (emphasis omitted). *See also* MINN. STAT. § 626.5572 subdiv. 21(4)(i)–(ii) (2012) (stating that functional test vulnerability is regardless of residence or whether any type of service is received).

[154] Janus, *supra* note 150, at 3.

[155] *See* Janus, *supra* note 150, at 4.

[156] MINN. DEP'T OF HUMAN SERVS., GUIDELINES TO THE INVESTIGATION OF VULNERABLE ADULT MALTREATMENT, MN.GOV 12 (2010) [hereinafter MINN. GUIDELINES], *available at* http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_139381.pdf.

[157] MINN. STAT. § 626.5572 subdiv. 17(b) (2012).

[158] MINN. GUIDELINES, *supra* note 156, at 50 (emphasis omitted).

[159] MINN. R. 9555.7300 subpt. 1 (2012).

Minnesota rules do specify that if an allegation involves, or is related to, a nursing facility, the local social services agency will notify the respective agency (i.e., the Department of Health) and that agency becomes the lead investigative agency.[160] This requirement, however, does not leave the local social services agency out of the investigative picture. First, if the allegation comes from a nursing facility social worker and concerns an individual who is suspected of, or at high risk upon discharge for, self-neglect, this case is not necessarily "involving" or "related to" the facility; it is primarily about a patient's own desire to return home in the context of a concern that the elderly person will self-neglect. In this scenario, APS could remain the lead investigative agency if there is no alleged wrongdoing by the facility. In addition, Minnesota rules state that the local social services agencies "shall cooperate *in coordinating its investigation* with the investigations of the licensing agencies . . . ."[161]

Minnesota's Vulnerable Adult Act APS provisions are an effective match to Ohio's needs. First, they affirmatively include individuals in nursing facilities under their definition of vulnerable adults.[162] As has been discussed previously, Ohio law specifically excludes individuals in nursing facilities from APS jurisdiction[163] which, with the transitory nature of today's elderly in and out of nursing facilities, no longer makes sense. Ohio needs to remove this artificial exclusion and expand APS jurisdiction into nursing facilities.

Secondly, in Minnesota, concerns related to vulnerable adults are directed to the local human services office as the common entry point.[164] Minnesota's local human services office would be analogous to Ohio's Job and Family Services county offices, in which APS is housed. The Minnesota structure would allow the local APS agency to be the initial screener of the concern, while allowing the flexibility of the Ohio Department of Health to remain the investigator for concerns/allegations that involve or are related to nursing facilities. Otherwise, APS can investigate, advocate, and take the necessary action to assist a vulnerable adult when they are at risk for self-neglect after returning home. In addition, Ohio should follow Minnesota's lead in adding a statutory requirement that APS cooperate in coordination of its investigation with the licensing agencies, including the Department of Health when appropriate.[165]

2. Mississippi Law

Mississippi passed its APS statutes in 1986, and similar to Minnesota, uses the concept of the vulnerable person in identifying who is eligible for APS services.[166] Mississippi defines the vulnerable person as

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[160] MINN. R. 9555.7300; MINN. STAT. § 626.5572 subdiv. 13 (2012).

[161] MINN. R. 9555.7300 subpt. 1 (emphasis added).

[162] MINN. STAT. § 626.557 subdiv. 1 (2012).

[163] *See* Stiegel & Klem *supra* note 146, at 21–22.

[164] MINN. GUIDELINES, *supra* note 156, at 12, 93–95.

[165] *See* MINN. R. 9555.7300 subpt. 1.

[166] MISS. CODE ANN. § 43-47-3 92012. The statutes were originally enacted under the Mississippi Vulnerable Adults Act of 1986. *History*, DIV. OF AGING & ADULT SERVS., MISS. DEP'T HUMAN SERVS., http://www.mdhs.state.ms.us/aas_aps.html (last visited Jan. 10, 2014).

> a person, whether a minor or adult, whose ability to perform the normal activities of daily living or to provide his or her own care or protection from abuse, neglect, exploitation or improper sexual contact is impaired due to a mental, emotional, physical, developmental disability or dysfunction, or brain damage or the infirmities of aging.[167]

Similar to Ohio,[168] Mississippi integrates its definition of self-neglect into the definition of neglect.[169]

A threshold requirement to meeting the Mississippi neglect definition could be restrictive in application to the elderly patient who is temporarily staying in a nursing facility. Specifically, the statute states that neglect occurs when the vulnerable person *who is living alone* is unable to provide for him or herself.[170] An elderly person, who has been hospitalized and then transferred to a nursing facility for additional rehabilitation, is not alone and daily needs are being provided for by staff.

There is a proviso in the definition of vulnerable, however, that may ameliorate this problem. Section 43-47-5(q) of the Mississippi Annotated Code states that "the department shall not be prohibited from investigating, and shall have the authority and responsibility to fully investigate . . . any allegation of . . . neglect . . . regarding a patient in a care facility, if the alleged . . . neglect occurred at a private residence."[171] This language supports APS's duty to investigate when self-neglect is suspected to have been occurring at home prior to hospitalization. Mississippi's statutory language would be beneficial to clarifying Ohio APS's role with elderly patients who are temporarily in a nursing facility and exhibit indicators of self-neglect when in the community.

The Mississippi Administrative Code further supports this proposition. Under the APS Investigation section of the Mississippi Administrative Code, it states that the department is statutorily prohibited from investigating or evaluating allegations of neglect of patients or residents in a care facility.[172] It further states, however, that "[a]n APS report should be accepted for investigation if an alleged victim is temporarily in a safe environment, such as a hospital or other temporary residence at

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APS responsibilities were initially assigned to the Division of Family and Children Services of the Department of Human Services. *Id.* Under legislation passed in 2006, the APS duties were then transferred to the Division of Aging and Adult Services. *Id.* Additionally, the name of the act was changed to the Mississippi Vulnerable Persons Act in 2010. *Id.*

[167] MISS. CODE ANN. § 43-47-5(q) (2012).

[168] OHIO REV. Code Ann. § 5101.60 (K) (LexisNexis 2011).

[169] MISS. CODE. ANN. § 43-47-5(m) (2012) ("'Neglect' means either the inability of a vulnerable person who is living alone to provide himself the food, clothing, shelter, healthcare or other services which are necessary to maintain his mental or physical heal, or failure of a caretaker to supply the vulnerable person . . . . 'Neglect' includes, but is not limited to, a single incident.").

[170] *Id.*

[171] MISS. CODE ANN. § 43-47-5(q) (2012).

[172] MISS. CODE ANN. § 43-47-9(2) (2013) (limiting investigation of abuse and exploitation allegations also).

the time of the APS report and the incident occurred at the victim's home . . . ."[173] As has been discussed, a large percentage of elderly individuals admitted into a nursing facility have temporary stays.[174] After receiving rehabilitation or skilled nursing services like intravenous medication, many of them return to their own homes.[175] This language should also be considered when adapting Ohio statutes and administrative codes pertaining to APS.

Lastly, the Mississippi Administrative Code provides additional clarifying language as to what constitutes self-neglect. Ohio could add similar language to partially address the deficiencies in its current APS language. Mississippi states that self-neglect results from an individual's difficulty in obtaining, maintaining, and/or managing the necessities of life independently.[176] The code then lists those necessities as including food, clothing, shelter, health care, income. and financial management.[177]

3. Proposed Changes to Ohio APS Law Regarding Jurisdictional Matters

Ohio needs to revise its laws to address what has been called a "serious and burgeoning health challenge"[178] and even a "growing epidemic"[179]—elder self-neglect. The laws also need to be changed in a way that reflects the more transitory nature of the elderly population in the healthcare system.[180] These changes should be based on a statutory provision that defines self-neglect separately from other forms of abuse. Self-neglect is the most reported type of abuse to APS,[181] but only eight states have given it separate recognition in their statutes.[182] As the state with the eighth largest elderly population in the nation,[183] Ohio needs to recognize self-neglect as a problem separate from other forms of abuse.

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[173] *Id.*

[174] *See* DECKER, *supra* note 17, at 2.

[175] *See* MEHDIZADEH ET AL, *supra* note 20, at 1–2.

[176] MISS. CODE ANN. 43-47-5 (2003) (providing that necessities include food that meets at least minimum nutritional requirements, clothing and shelter required for safety, health care adequate to prevent or treat debilitating mental or physical conditions, income and financial management to handle routine and personal care expenses).

[177] MISS. CODE ANN. 43-47-5(h)–(n) (2013).

[178] Naik et al, *supra* note 54, at 24.

[179] Pavlou & Lachs, *supra* note 7, at 1841.

[180] *See* DECKER, *supra* note 17, at 1.

[181] TATARA & KUZMESKUS, *supra* note 3 at 1; *see also Elder Abuse, Neglect and Exploitation, Jan. 1, 2011–Dec. 31, 2011*, CUYAHOGA CNTY. ADULT PROTECTIVE SERVS., http://dsas.cuyahogacounty.us/en-US/adult-protective-services-statistics.aspx (last visited Jan. 8, 2014).

[182] STIEGEL & KLEM, *supra* note 31 (listing jurisdictions that define self-neglect from other forms of abuse: Colorado, District of Columbia, Louisiana, Maryland, Utah, Washington, Wisconsin, and Wyoming).

[183] ADMIN. ON AGING, *supra* note 8, at 6, 9. Ohio is one of seventeen states where the elderly population constitutes at least fourteen percent or more of the population. ADMIN. ON AGING, *supra* note 8, at 6.

Ohio could adopt the National Center on Elder Abuse definition, which defines self-neglect as "behavior of an elderly person that threatens his/her own health or safety" and is manifested by a "refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions."[184] The definition also includes the exception that self-neglect is not "a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice."[185] Ohio should adopt both components of the definition as it strikes a careful balance. First, the definition includes most of the "necessities" listed in the Mississippi Annotated Code, with the exception of financial management.[186] Second, it upholds the elderly person's right to make bad decisions[187] as long as they are informed.

Minnesota's and Mississippi's laws and administrative codes shed light on potential changes for Ohio's APS laws.[188] These changes could benefit the increasing number of elderly individuals who are at risk of self-neglect by closing the current jurisdictional gap that exists for APS in nursing facilities.[189] First, Ohio should remove the "independent living arrangement" exception in the definition of an adult.[190] In addition, Ohio should replace "adult" with "vulnerable adult," and affirmatively include in this category individuals "who are a resident of, patient of, or are dependent on an institution."[191]

Secondly, Ohio should delineate the jurisdictional line between the Ohio Department of Health and APS under Section 5101.62 of the Ohio Revised Code in

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[184] NAT'L CTR. FOR ELDER ABUSE, *supra* note 2.

[185] NAT'L CTR. FOR ELDER ABUSE, *supra* note 2.

[186] *See* MISS. CODE ANN 43-47-5(h)–(n) (2003). Financial management should be included in Ohio's definition as those who self-neglect are at an increased risk for abuse by others, including financial exploitation.

[187] *See* Connolly, *supra* note 24, at S247.

[188] Ohio has a significantly larger elderly population than Minnesota and Mississippi. CARRIE A. WERNER, U.S. CENSUS BUREAU, THE OLDER POPULATION: 2010 9 (2011). As of 2010, Ohio had 1.6 million residents who were sixty five years or older, whereas Minnesota had 683,121, and Mississippi had 380,407. *Id.* The argument could be made that statutory structures from states with smaller elderly populations cannot be effectively applied in Ohio because of this disparity. This proposition is weakened, however, when one considers the percentage of elderly compared to the total population of each state. Ohio's elderly population makes up 14.1% of the total state population, and Minnesota's and Mississippi's percentages are not far behind, at 12.9% and 12.8%, respectively. *Id.* Additionally, Minnesota's elderly population grew at almost double the rate of Ohio's, at 15.0% and 7.6% respectively, from the year 2000 to year 2010 censuses. *Id.* Mississippi also had a higher percentage change than Ohio, at 10.7% in the same time frame. *Id.* Ohio's larger elderly population would indicate a greater need for evolution in APS services that can be achieved by considering what has been done in other states with a similar percentage of elderly compared to the total population within those respective states. *Id.*

[189] *See supra* III(A)–(B).

[190] OHIO REV. CODE ANN. § 5101.60(K) (LexisNexis 2011).

[191] MISS CODE ANN. § 43-47-3 (2003); MINN. STAT. § 626.557(1) (2012).

congruence with the new category and definition of vulnerable adult. Under this section, the investigational duties of APS are identified.[192] Currently, the statute begins "the county department of job and family services [APS] shall be responsible for the investigation of all reports provided for in section 5101.61 . . . and for evaluating the need for and, to the extent of available funds, providing or arranging for the provision of protective services."[193] After this sentence, additional language could be added to cover the gap that currently exists for APS and to provide the necessary jurisdiction to see nursing facility patients if the concern of neglect does not involve, or is related to, the facility—for example: "any reports *not involving or relating to*[194] a licensed facility shall be investigated by the county department of jobs and family services [APS]. All other reports will be investigated by the Ohio Department of Health."

Third, the APS statutes could be additionally strengthened by adding the Mississippi proviso[195] that confirms APS's authority to investigate allegations that have occurred in the community. In the Ohio Revised Code, language could be added under the APS investigation section[196] to meet this goal, as follows: "the department [APS] shall not be prohibited from investigating, and shall have the authority and responsibility to fully investigate, in accordance with the provisions of this chapter, any allegation of abuse, neglect, or exploitation regarding a patient in a care facility, if the alleged abuse, neglect, or exploitation occurred at a private residence."[197] This additional language would reinforce APS's authority in situations where a self-neglecting individual is admitted to a nursing facility, the staff strongly suspects the patient was self-neglecting at home, and the patient's intention is to return home after a short-term stay in the nursing facility. While the expansion of APS jurisdiction would be a positive step in addressing the problem of elderly self-neglect, this change is not sufficient. Ohio must additionally evolve APS investigational and interventional structures in order to address the increasingly complex cases that this agency faces. A more developed APS response will decrease the likelihood that elderly individuals will face loss of independence, significant injury, or even death.

IV. DEVELOPING A DIFFERENTIAL RESPONSE FOR ADULT PROTECTIVE SERVICES

Ohio statutory and administrative guidance for the provision of APS is also inadequate to address the needs of self-neglecting elderly or those at risk of self-

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[192] OHIO REV. CODE ANN. § 5101.62 (LexisNexis 2011).

[193] *Id.*

[194] *See* MINN. R. 9555.7300 (2007); MINN. STAT. § 626.5572 subdiv. 13 (2012). This language is used in the respective Minnesota rule in outlining the process of initial investigation when a facility is involved, MINN. R. 9555.7300. Although the local social services agency is the initial investigator, the Department of Health becomes the lead investigator for nursing facilities. MINN. STAT. § 626.5572 subdiv. 13. Here, the terms "involve" and "related to" are being used to affirm APS jurisdiction when the report is not concerning care or treatment by facility staff. MINN. STAT. § 626.5572 subdiv. 13.

[195] MISS. CODE ANN. § 43-47-5(q) (2003).

[196] OHIO REV. CODE ANN. § 5101.62 (LexisNexis 2011).

[197] MISS. CODE ANN. § 43-47-5(q) (2003).

neglect. In general, there is a dearth of research in the area of elder neglect.[198] Forensic science relating to elder abuse and neglect is *forty years* behind what has been done in child abuse.[199] A commentator noted recently that researchers are showing a tendency to conceptualize self-neglect as its own phenomenon separate from the general discussion of abuse and neglect in the elderly population.[200] The provision of effective adult protective services is truly in its infancy when compared to child protective services.

Over the last twenty years, research and pilot programs by various states have advanced child protective services beyond the default investigatory response to child welfare concerns.[201] While child protective services has advanced "differential" or "alternative responses" to allegations of abuse and neglect,[202] the states have not made analogous advances when addressing the problem of elderly abuse and neglect. Ohio is no exception to the lack of evolution in APS practices. Ohio passed enabling legislation for an alternative response approach pilot program in 2006 for Public Children Services Agencies;[203] no such changes have been proposed for APS. In order to address the complex problems of self-neglecting elderly, Ohio needs to develop multiple tracks of response for allegations of elderly neglect and abuse, similar to the procedures within the child protective services field.

A. Child Protective Services and Differential Response

Historically, reports of child abuse or neglect received an investigative response, in which the agency worker determined if the child had been harmed (or was at risk for harm) and provided protection if needed.[204] The investigation focused on a particular reported incident, and the primary purpose was to determine "findings" related to the allegations.[205] In addition, perpetrators and victims were to be

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[198] *See* Dong et al, *supra* note 73 at 203; Carmel Bitondo et al., *Future Research: A Prospective Longitudinal Study of Elder Self-Neglect*, 56 J. AM. GERIATRICS SOC'Y, 261 (2008); Band-Winterstein, *supra* note 35, at 110.

[199] Connolly, *supra* note 24, at S247.

[200] Band-Winterstein, *supra* note 35.

[201] NAT'L QUALITY IMPROVEMENT CTR., DIFFERENTIAL RESPONSE IN CHILD PROTECTIVE SERVICES: A LITERATURE REVIEW 1, 4–8 (2009), *available at* http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/qicdr/General%20Resources/QIC-DR_Lit_Review%20version%20%202.pdf [hereinafter QUALITY CENTER]; Marie Connolly, *Differential Responses in Child Care and Protection: Innovative Approaches in Family-Centered Practice*, 20 PROTECTING CHILDREN 8, 13 (2005).

[202] QUALITY CENTER, *supra* note 201, at 4.

[203] *See* S.B. 238 § 3, 126th Gen. Assemb. (Ohio 2006), *available at* http://legislature.state.oh.us/bills.cfm?ID=126_SB_238; *Differential Response Approach: State Enacted Leg.*, NAT'L CONFERENCE OF STATE LEG., http://www.ncsl.org/issues-research/human-services/state-legislation-differential-response.aspx (last updated Mar. 2013) [hereinafter NCSL].

[204] CHILD WELFARE INFORMATION GATEWAY, DIFFERENTIAL RESPONSE TO REPORTS OF CHILD ABUSE AND NEGLECT 4 (2008), *available at* http://www.childwelfare.gov/pubs/issue_briefs/differential_response/differential_response.pdf [hereinafter CHILD WELFARE].

[205] Patricia Schene, *The Emergence of Differential Response*, 20 PROTECTING CHILDREN 4, 5 (2005).

identified.[206] These investigations were often adversarial in nature.[207] On the other hand, some reports that were considered to be of lower risk or severity were screened out or closed without further action.[208] As caseloads grew and the complexities of the complaints increased, the child protective services field generally became dissatisfied with this "one size fits all" approach.[209]

In 1993, Missouri and Florida passed legislation which enacted differential or alternative responses to allegations of child abuse or neglect.[210] By 1999, Missouri's system was implemented statewide and has been used as a model for other states.[211] Thirty states now have either pilot or statutorily-established alternative response programs in place.[212] The basic theory behind differential or alternative response is "that the response to reports of abuse or neglect should be commensurate with the risk level"[213] and that it allows for more than one method of response.[214]

Instead of being incident-based, the focus of alternative response is on assessment of the family's strengths[215] and underlying conditions and factors that contribute to the risk of harm for the child.[216] Under this pathway, one of the goals is to engage the family and enhance their cooperation in formulating effective interventions.[217] This cooperation requires the family's consent to an assessment of the child's safety and protection needs.[218] Interventions are individualized to the particular situation and are coordinated with appropriate community services.[219]

B. Ohio's Foray into Differential Response

Ohio's own pilot program for a differential response system in child protective services has been developed to meet the needs unique to Ohio, while also integrating effective practices of other states.[220] The investigative response pathway remains in

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[206] *Id.*

[207] *Id.*

[208] CHILD WELFARE, *supra* note 204, at 6.

[209] CHILD WELFARE, *supra* note 204, at 6.

[210] QUALITY CENTER, *supra* note 201, at 4.

[211] QUALITY CENTER, *supra* note 201, at 4.

[212] NCSL, *supra* note 203.

[213] Lisa Merkel-Hoguin, *Differential Response: A Common Sense Reform in Child Welfare*, 20 PROTECTING CHILDREN 2, 2 (2005).

[214] Schene, *supra* note 205, at 4.

[215] CHILD WELFARE, *supra* note 204, at 8.

[216] Schene, *supra* note 205, at 5.

[217] Ying-Ying T. Yuan, *Potential Policy Implications of Alternative Response*, 20 PROTECTING CHILDREN 22, 22 (2005).

[218] *Id.* at 25.

[219] CHILD WELFARE, *supra* note 204, at 8.

[220] NAT'L CTR. FOR ADOPTION LAW & POLICY, AM. HUMANE INST. OF APPLIED RESEARCH MINNESOTA CONSULTANTS, RECOMMENDATIONS FOR A DIFFERENTIAL RESPONSE

place, and certain allegations *require* an investigation, including: felony child endangerment or domestic violence, criminal sexual conduct, and homicide.[221] Under the pilot program, however, low to moderate risk cases can be assigned to the alternative response pathway in which a formal disposition that maltreatment has occurred is not required.[222] Instead, the protective services worker focuses on collaboration with the family by respecting their strengths and resources, identifying their values and cultural traditions, and honoring the wisdom they have about their own circumstances.[223] It has been recommended that by 2015, all eighty-eight Ohio counties implement alternative response pathways.[224]

C. Applying Differential Response to Adult Protective Services

What child protective services does for its clients is not completely congruent to APS's resources or legal capabilities in the realm of serving elderly adults. The problems that adult and child clients present to their respective protective services are, in some respects, not comparable.[225] In addition, society has arguably viewed its duties to the young and old differently and has allocated resources accordingly.[226] In a national survey of APS administrators, fifty-seven percent reported that insufficient funding was a major problem.[227] Further, several of the administrators found speaking with state legislators futile, as the legislators viewed APS as a competitor

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STATUTORY/RULE FRAMEWORK IN OHIO 4, *available at* www.sconet.state.oh.us/Boards/familyCourts/ARPilot/Section3.pdf.

[221] CAREN KAPLAN ET AL., AM. HUMANE INST. OF APPLIED RESEARCH MINNESOTA CONSULTANTS, OHIO ALTERNATIVE RESPONSE PILOT PROJECT FINAL REPORT OF THE AIM TEAM, 40 (2010), *available at* http://www.americanhumane.org/assets/pdfs/children/differential-response/pc-dr-ohio-section1-aim-final-report.pdf.

[222] OHIO DEP'T OF JOB & FAMILY SERVICES, REQUEST FOR APPLICATIONS: OHIO DIFFERENTIAL RESPONSE EXPANSION, R-1011-06-8076 §1.1 (2011), *available at* http://jfs.ohio.gov/RFP/.

[223] ANTHONY NORWOOD, AM. HUMANE INST. OF APPLIED RESEARCH MINNESOTA CONSULTANTS, ALTERNATIVE RESPONSE FUNDAMENTALS IN SUPPORT OF OHIO'S CHILD PROTECTION PRACTICE MODEL app. B at 3 (2010), *available at* http://law.capital.edu/uploadedFiles/Law_Multi_Site/NCALP/Appendix_B.pdf.

[224] *See* KAPLAN, *supra* note 221, at 112.

[225] While the author considers applying a differential response structure used in child protective services to the APS system, the author is in no way proposing that adults' legal rights and independence are equated to that of children's. There is little question, however, that the field of child protective services has developed an investigative and interventional system in response to the increasing complexity of cases, whereas APS has not. Child protective services' differential response system can provide at least a starting point to overhauling a weak APS system.

[226] JOANNE OTTO, NAT'L ASS'N ADULT PROTECTIVE SERVICES ADM'RS, PROBLEMS FACING STATE ADULT PROTECTIVE SERVICE PROGRAMS AND THE RESOURCES NEEDED TO RESOLVE THEM, 3–4 (2003), *available at* www.ncea.aoa.gov/main_site/pdf/publication/NAAPSA7.pdf.

[227] *Id.*

for child protective services funds.[228] The administrators felt that APS was not a priority in comparison to child protective services.[229]

The field of child protective services, however, has developed a system of assessment that focuses on the client and not the alleged incident(s) of abuse or neglect in many cases. APS should adopt some aspects of this differential response and better serve the increasingly complex elderly population, especially in the area of self-neglect.

Currently, Ohio statutes and administrative code reflect only an investigative focus of APS.[230] After an investigation, "the department shall determine from its findings whether or not the adult who is the subject of the report is in need of protective services."[231] Further, the expectation of collaboration with the elderly person is unclear; it requires that APS involve the adult.[232] The statute does not further specify how or to what degree the adult is involved in the APS assessment.[233] The only other related requirement is that the caseworker must obtain the signature of the elderly client on the APS plan,[234] but the importance of this requirement to the APS intervention is unclear.

Ohio should pass enabling legislation for a pilot differential response program to address allegations of elderly self-neglect.[235]A differential response system could be used in lieu of the lone investigative track of current APS law in many self-neglect cases. An assessment of the elderly client's underlying situation would replace the investigative focus for a potential victim or perpetrator of abuse or neglect. Further, the APS caseworker would focus on collaborating with the elderly client and not merely involving them.[236] In addition, the investigation (or agency worker) would not determine whether the elderly person was in need of APS,[237] but rather the decision would be made cooperatively with the elderly person. Consent would remain a hallmark of the provision for APS for those who have the capacity to do so.

The addition of an alternative response program to the provision of APS would not replace the traditional investigative track. As with the child protective services program, certain allegations or evidence would be directed to the traditional

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[228] *Id.*

[229] *Id*.

[230] *See generally*, OHIO ADMIN. CODE 5101:2-20-02(E)–(K); OHIO REV. CODE ANN. § 5101.62 (LexisNexis 2011).

[231] OHIO REV. CODE ANN. § 5101.62 (2012).

[232] OHIO ADMIN. CODE 5101:2-20-02(K)(6) (2012).

[233] *Id.*

[234] OHIO ADMIN. CODE 5101:2-20-02(K)(2)(e) (2012).

[235] Differential or alternative responses would also be beneficial for allegations of elder abuse or neglect not self-inflicted, but this topic is outside the scope of this paper. As more family members in the "sandwich" generation feel the pressures and stress of taking care of or helping the elderly at home, a differential response to alleged abuse or neglect by these individuals would promote the elderly person's continued community living while providing support and education to the caregiver instead of a more punitive or fault-finding response.

[236] OHIO ADMIN. CODE 5101:2-20-02(K)(6) (2012).

[237] OHIO REV. CODE ANN. § 5101.62 (2012).

investigative pathway.[238] Also similar to the structure of some child differential programs,[239] refusal to consent would result in reassignment to the investigative pathway if the threat of harm is significant or lack of capacity to consent is suspected.

One of the concerns of differential response in the child protection field has been that child safety may be compromised when this track is used.[240] Studies have not supported this concern, although it could be argued that the cases were lower risk from the beginning.[241] Analysis of data from the National Child Abuse and Neglect Data System did not support this lower risk hypothesis.[242] Instead, the study showed that when cases were randomly assigned to either investigation or alternative response, the alternative response cases were less likely to be re-reported than investigation cases.[243] Similar research would need to be completed with the elderly population to test the impact of alternative response. Lastly, alternative response may strike an effective balance between shoring up the self-determination rights of the elderly adult and decreasing the risk factors for self-neglect. The development of APS's interventional structure and expansion of its jurisdiction will entail additional funding. The next section reviews this issue.

V. FUNDING

Increasing the quality and quantity of APS activity in protecting the elderly clearly presents significant financial challenges.[244] Kathleen Quinn, Executive Director of the National Adult Protective Services Association, testified to the Senate Special Committee on Aging that "APS workers . . . are the 'boots on the ground' in the fight against elder abuse."[245] Across the country, however, APS resources are insufficient to meet the increasing caseloads and complexity of APS

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[238] *See* KAPLAN, *supra* note 221, at 40 (providing circumstances in child protective services where the traditional investigatory pathway must be used).

[239] *See* QUALITY CENTER, *supra* note 201, at 2, 13.

[240] Gila R. Shusterman et al., *Alternative Responses to Child Maltreatment: Finding from NCANDS*, 20 PROTECTING CHILDREN, 32, 34 (2005).

[241] *Id.*

[242] *Id.*

[243] *Id.*

[244] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-208, ELDER JUSTICE: STRONGER FEDERAL LEADERSHIP COULD ENHANCE NATIONAL RESPONSE TO ELDER ABUSE 17–18 (2011) [*hereinafter* STRONGER FEDERAL LEADERSHIP].

[245] KATHLEEN M. QUINN, NAT'L ADULT PROTECTIVE SERVICES ASS'N [NAPSA], HEARING ON JUSTICE FOR ALL ENDING ELDER ABUSE, NEGLECT, AND FINANCIAL EXPLOITATION 2 (Mar. 2, 20011), *available at* http://www.aging.senate.gov/events/hr230kq.pdf. Quinn does specifically include self-neglect in her discussion of abuse and refers to the problem as a "huge category of APS clients." *Id* at 4. While citing human compassion as a reason society should be concerned with self-neglecters, she also refers to the financial costs associated with the problem: repeated health care interventions, repeated calls to public health, zoning and fire code enforcement agencies and animal control. *Id* at 4. NAPSA is a nonprofit organization which represents state APS programs across the country. *Id.*

cases.[246] Criticism has been levied against the federal government for not providing better leadership to address the problem.[247]

With no single stream of funding for APS agencies, states and their counties must put together a patchwork budget from various funding sources.[248] Funding sources include the Department of Justice, Medicaid, Older Americans Act grants, Social Services Block (SSBG) grants, and the states themselves.[249] Federal funding for elder abuse, however, has historically been diminutive compared to other protection fields. For example, in 2002, the U.S. Senate Special Committee on Aging reported that approximately $153.5 million was spent on elder abuse programs, while $520 million and $6.7 billion had been allocated to domestic violence and child abuse prevention respectively.[250] Note also that the Administration on Aging requested a $2 billion budget for the entire agency for fiscal year 2013.[251]

The Elder Justice Act (EJA), passed in March 2010 as part of the Patient Protection and Affordable Care Act, was the first time that federal funds were specifically authorized for APS.[252] Over $400 million dollars were authorized for APS over four years.[253] Unfortunately, uncertainty exists as to how much funding will actually be appropriated.[254]

While the EJA placed a spotlight on elder abuse and neglect, it unfortunately has had little impact on the financial matters of state budgets and the availability of increased funds for APS agencies. SSBG grants have been on the decline since the 1980's.[255] Even the continued availability of SSBG's was recently questioned when

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[246] STRONGER FEDERAL LEADERSHIP, *supra* note 244, at 17–18.

[247] *See* Lindberg et al, *supra* note 109, at 105–09.

[248] NAT'L ASS'N OF STATES UNITED FOR AGING & DISABILITIES, ADULT PROTECTIVE SERVICES IN 2012: INCREASINGLY VULNERABLE 12 (2012), *available at* http://www.apsnetwork.org/research/BaselineSurveyFinal.pdf [hereinafter VULNERABLE].

[249] *Id*. at 12. SSBG and Medicaid funds are the largest sources of federal funding for APS programs. STRONGER FEDERAL LEADERSHIP, *supra* note 244, at 27. SSBG funds, however, are allocated at each state's discretion according to the state's priorities. JOANNE M. OTTO, NAT'L ADULT PROTECTIVE SERVICES ASS'N, ADULT PROTECTIVE SERVICES PROGRAMS STATE ADMINISTRATIVE STRUCTURES [hereinafter STATE ADMINISTRATIVE STRUCTURES] 4 (2007), *available at* http://www.aspnetwork.org/Resources/docs/Administrative%20Structure%20Report.pdf. Funding of APS through SSBG funds consequently varies greatly. *Id.* Of 42 states, 15 states used SSBG funds at a total of $100 million. *Id.* The allocations that New York and Texas made to APS from these SSBG funds represent over two-thirds of this total. *Id.*

[250] Lisa Nerenberg, *Communities Respond to Elder Abuse*, 46 J. GERONTOLOGICAL SOC. WORK, 5, 20 (2006).

[251] U.S. DEPT. OF HEALTH AND HUMAN SERV., FISCAL YEAR 2013 BUDGET IN BRIEF 100 (2012), *available at* http://www.hhs.gov/budget/budget-brief-fy2013.pdf. OAA grants, however, represent only .25% of the total APS funding, STATE ADMINISTRATIVE STRUCTURES, *supra* note 249.

[252] POLICY FORUM, *supra* note 63, at 2–3.

[253] *See* Stiegel, *supra* note 63 at 1.

[254] *See* STRONGER FEDERAL LEADERSHIP, *supra* note 244, at 27.

[255] Lindberg et al, *supra* note 109, at 109.

the House Ways and Means Committee voted on eliminating SSB altogether as an attempt to generate savings for the House-approved budget.[256] Additionally, the United States Government Accountability Office (GAO) found that sixty-six percent of the states surveyed reported that total APS funding had stayed the same or decreased over the last five years.[257] Unfortunately, while the financial pressures mount, the demand for APS is only increasing for a large majority of states.[258]

Ohio has not been exempt from the economic struggles and the ensuing political battles.[259] In 2011, the state faced an $8.6 billion deficit for the two-year budget cycle.[260] In 2012, the Ohio Legislature rejected a bill that would have restricted public employees' rights to collectively bargain; commentators voiced that programs like Medicaid would consequently see cuts.[261] Ohio allocated approximately $13 million of their SSBG to APS program funds for fiscal year 2009. Expenditure comparisons with other states are difficult because of the different funding structures, and some states did not provide complete funding information, including Ohio for a recent GAO report.[262] In a 2007 report by the National Adult Protective Services Association, Ohio ranked twenty-sixth amongst thirty-two states surveyed in per capita state funding of APS services at $.26.[263] Additionally, Ohio APS's one line item for the fiscal year 2012−13 budget was cut by 10% from the prior year, a 37% reduction from 2009.[264]

Allocating additional funding for the changes discussed in this paper would be challenging, especially considering this current economic environment at both the state and federal level. In order to propose additional funding, unit costs of the current program would need to be calculated.[265] This analysis would include a breakdown of costs associated with specific tasks and services provided by APS.[266] The cost analysis would be beneficial in several different ways, including:

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[256] Indivar Dutta-Gupta, *Eliminating Social Services Block Grant Would Weaken Services for Vulnerable Children, Adults, and Disabled*, CTR ON BUDGET & POL'Y PRIORITIES 1 (May 3, 2012), http://www.cbpp.org/files/5-3-12bud.pdf.

[257] STRONGER FEDERAL LEADERSHIP, *supra* note 244, at 18.

[258] VULNERABLE, *supra* note 248, at 13 (reporting that eighty-five percent of states have experienced an increase in caseloads over the last five years).

[259] *See e.g.*, Phil Oliff et al., *States Continue to Feel Recession's Impact*, CTR. ON BUDGET & POL'Y PRIORITIES 1 (June 27, 2012), http://www.cbpp.org/files/2-8-08sfp.pdf; Amanda Terkel, *John Kasich Unveils Budget Cut Plan*, HUFFINGTON POST, Mar. 15, 2011, http://www.huffingtonpost.com/2011/03/15/john-kasich-unveils-budge_n_836105.html; Sarah Steman, *Ohio Budget May Face Cuts from Issue 2*, LANTERN (last updated June 16, 2012, 1:06 AM).

[260] Terkel, *supra* note 259.

[261] Steman, *supra* note 259.

[262] STRONGER FEDERAL LEADERSHIP, *supra* note 244, at 50–51.

[263] STATE ADMINISTRATIVE STRUCTURES, *supra* note 249, at 7.

[264] STATE OF OHIO, THE EXECUTIVE BUDGET, FISCAL YEARS 2012 and 2013 D-310.

[265] *See* JOANNE M. OTTO, NAT'L ASS'N OF ADULT PROTECTIVE SERVICES ADMINISTRATORS, EVALUATION OF OHIO'S ADULT PROTECTIVE SERVICES RECOMMENDATIONS 36 (2007), *available at* apsnetwork.org/Resources/docs/EvaluationOhio2001.pdf.

[266] *Id.*

highlighting those services that could be provided more efficiently by other organizations or agencies, prioritizing exploration of funding sources per the types of activities completed by APS workers, and making cost projections for new programs more realistic.[267]

New sources of funding should also be considered. The Ohio Coalition of Adult Protective Services has advocated an amendment that would add a $50 fee to every funeral.[268] They argue that while increasing the cost of an average funeral by only 1%, the fee would generate $5.4 million for APS per year.[269] County tax levies have also been proposed, and in counties that already have them, a portion of the funds should be earmarked for APS.[270] Finally, appeals to increase funding should continue to be made to the state legislature and to the public.[271] Low funding levels have been blamed on the fact that APS lacks visibility and is not understood by the public and many professionals.[272] Advocacy agencies, such as the Ohio Coalition for Adult Protect Services, need to continue their efforts in educating the public.[273]

VI. CONCLUSION

There is little debate that the risk and actual occurrence of elderly self-neglect will only increase over the coming decades.[274] The elderly population is rapidly increasing in the United States as the Baby Boomer generation ages.[275] People are living longer, but yet at the same time less of the elderly are living in nursing facilities on a long-term basis.[276] Instead, more elderly are living at home later in life.[277] Nursing facilities, however, remain important on this spectrum as the elderly are likely to have at least one, and sometimes multiple, stays that are short-term.[278]

Self-neglect is more likely to occur than any other form of abuse against the elderly.[279] The likelihood that community members would become aware of a self-neglecting individual is low.[280] The nature of self-neglect is that help is rarely sought, and the problems are most often hidden from others.[281] Removing the APS

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[267] *Id.*

[268] OHIO COAL. FOR ADULT PROTECTIVE SERVICES, LETTER TO OHIO SENATORS, *available at* http://www.ocapsohio.org/default.asp?contentID=584.

[269] *Id.*

[270] OTTO, *supra* note 249, at 39.

[271] *Id*; Nerenberg, *supra* note 250, at 19.

[272] Nerenberg, *supra* note 250, at 19.

[273] *See* Nerenberg, *supra* note 250, at 19.

[274] Pavlou & Lachs, *supra* note 7, at 1841; Dong, *supra* note 7 at 2292.

[275] U.S. CENSUS BUREAU, *supra* note 10, at 2.

[276] *See* DECKER, *supra* note 17 at 2.

[277] *See* DECKER, *supra* note 17 at 2.

[278] *See supra* note 19.

[279] TATARA & KUZMESKUS, *supra* note 3, at 1.

[280] Burnett et al, *supra* note 101, at 37.

[281] Burnett et al, *supra* note 101, at 37.

jurisdictional restriction for nursing facilities would allow caseworkers to establish an effective working relationship with an elderly person before she is discharged back to her home. APS should develop a plan with the elderly person that will minimize the risk of self-neglect while not interfering with the duties of other agencies including the Ohio Department of Health and The Long Term Care Ombudsman. Ohio needs to amend its statutes to allow APS jurisdiction over nursing facilities, at least for the circumstances described in this paper.

Lastly, Ohio needs to advance its APS provisions to provide a spectrum of intervention that is congruent to the complexity of self-neglect problems.[282] The one-size-fits-all mentality for investigating allegations of abuse and neglect is no longer effective.[283] As in the field of child protective services, a differential or alternative response system of intervention should be piloted to address the needs of this elderly population. By developing a more comprehensive interventional response and expanding APS jurisdiction in Ohio, elder-self neglect will be more effectively addressed.

[282] *See supra* Part IV(C).

[283] *See supra* Part IV(C).