

**DO I REALLY HAVE TO?: AN  
EXAMINATION OF MANDATORY  
REPORTING STATUTES AND THE CIVIL  
AND CRIMINAL PENALTIES IMPOSED FOR  
FAILURE TO REPORT ELDER ABUSE**

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*Despite the growing evidence that elder abuse is a severe and growing problem in the United States, Congress has been slow to enact legislation to rectify the issue. Due to inaction from the legislature, there is little guidance or support from the federal government as to how to address this ever-growing problem. Coupled with lack of funding, the lack of federal guidance on how to address elder abuse has hampered state mechanisms for prevention and detection of elder abuse. This Note examines mandatory state reporting statutes and the penalties they impose for failure to report suspected cases of elder abuse, and provides a recommendation for effective mandated reporting laws.*

## **I. Introduction**

Dennis Mathis, a seventy-eight-year-old resident of a California skilled nursing facility, depended on the care of staff to bathe and relieve himself due to paralysis on the left side of his body.<sup>1</sup> Instead of caring for Mr. Mathis, the certified nursing assistants (CNAs) at Mr.

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1. Pamila Lew et al., *Victimized Twice: Abuse of Nursing Home Residents, No Criminal Accountability for Perpetrators*, DISABILITY RIGHTS CALIFORNIA 1, 7 (Apr. 2010), <http://www.disabilityrightsca.org/pubs/548801.pdf> [hereinafter Lew].

Mathis's facility sexually assaulted and battered him.<sup>2</sup> The CNAs responsible for Mr. Mathis's care forced him to eat his own feces, pinched his nipples and penis, and twisted the skin on his arms.<sup>3</sup> For months Mr. Mathis told other staff members that he was afraid his abusers would kill him.<sup>4</sup> At least three other staff members witnessed the abuse.<sup>5</sup> But no one at the facility reported the abuse.<sup>6</sup> Unfortunately, stories like Mr. Mathis's story are all too common. Despite state statutes that mandate reporting of suspected cases of elder abuse, elder abuse remains severely underreported.<sup>7</sup>

In 1981, the House Select Committee on Aging held a series of hearings on elder abuse.<sup>8</sup> As a result of these hearings, the committee issued a report, *Elder Abuse: An Examination of a Hidden Problem*, in which they discussed the nature and prevalence of elder abuse in the United States.<sup>9</sup> The report determined that elder abuse was both widespread, with an estimated one million persons victimized by elder abuse annually and severely underreported.<sup>10</sup> Given the increase in the elderly population, elder abuse has become an even bigger problem and will continue to be a serious issue as the elderly population continues to grow.<sup>11</sup> In fact, in 2004, the National Center of Elder Abuse (NCEA) conducted a study showing a twenty percent increase in reports of elder and vulnerable adult abuse and a fifteen percent increase in substantiated reports of elder and vulnerable adult abuse.<sup>12</sup>

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2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.* at 7-8.

6. *Id.* at 8.

7. Molly Dickinson Velick, *Mandatory Reporting Statutes: A Necessary Yet Underutilized Response to Elder Abuse*, 3 *ELDER L. J.* 165, 167 (1995) (estimating that elder abuse is underreported by ninety percent) [hereinafter Velick].

8. *Id.* at 169.

9. Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect - the Legal Framework*, 31 *CONN. L. REV.* 77, 83 (1998) [hereinafter Moskowitz].

10. *Id.*

11. *Id.* at 86-87 ("[T]he proportion of those over eighty-five years old is growing faster than the number of elderly in general. Although representing only 1% of the population in 1980 (2.2 million), this over-age eighty-five segment will double to 2% by 2000 (4.6 million) and increase to more than 5% by 2050 . . . given the large and increasing number of cases of elder abuse and neglect, we can predict an increasing demand for services to deal with this problem."); see Joseph Barber, *The Kids Aren't All Right: The Failure of Child Abuse Statutes as a Model for Elder Abuse Statutes*, 16 *ELDER L. J.* 107, 109 (2008) [hereinafter Barber].

12. See Barber, *supra* note 11, at 110.

Some experts estimate that as many as two million elder Americans are victims of elder abuse each year.<sup>13</sup>

Despite the growing evidence that elder abuse is a severe problem in the United States, the legislature has been slow to act. In its 1981 Elder Abuse report, the House Committee on Aging recommended that Congress provide assistance to the states in aiding victims of elder abuse.<sup>14</sup> However, federal action was not forthcoming.<sup>15</sup> Congress considered H.R. 7551, the Elder Abuse Treatment & Prevention Act of 1980, but it was never enacted despite being brought up in several different sessions of Congress.<sup>16</sup> In 1991, the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging produced another report that criticized Congress for the past decade of "shame and inaction."<sup>17</sup> Because of this inaction, there is little guidance or support from the federal government as to how to address the problem of elder abuse.<sup>18</sup> Additionally, decreases in federal funding of elder abuse prevention programs lead to corresponding decreases in state funding.<sup>19</sup> The lack of funding, coupled with the lack of federal guidance on statutory responses to elder abuse, has hampered the state mechanisms for prevention and detection of elder abuse.

States have been slow to act on the issue of elder abuse as well. As late as 1977, not a single state had a statute that was targeted at

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13. U.S. GOV'T ACCOUNTABILITY OFF., GAO/HRD-91-74, ELDER ABUSE: EFFECTIVENESS OF REPORTING LAWS AND OTHER FACTORS 1, 1 (1991).

14. Moskowitz, *supra* note 9, at 84.

15. *Id.*; see also Barber, *supra* note 11, at 118 ("Since the early 1990s, congressional committees have held a series of hearings in an attempt to raise the elder abuse problem in the national conscience; all without tangible results.").

16. Moskowitz, *supra* note 9, at 84.

17. CHAIRMAN OF SUBCOMM. ON HEALTH AND LONG-TERM CARE, HOUSE SELECT COMM. ON AGING, HOUSE OF REPRESENTATIVES, 101ST CONG., ELDER ABUSE: A DECADE OF SHAME AND INACTION 1, 2 (Comm. Print 1990) [hereinafter ELDER ABUSE].

18. Moskowitz, *supra* note 9, at 84; Velick *supra* note 7, at 171 ("The report concluded that without more federal funding, the states are 'severely hampered in channeling monies into this newly designated social services area -- elder abuse protective services -- on their own authority.'").

19. See Barber, *supra* note 11, at 117-120 ("[M]any states had passed elder abuse statutes - using mandatory reporting laws - in the 1980s expecting to receive federal funding in reliance on the 1981 congressional report . . . states annually spent \$ 3.80 per elderly resident, on average, on elder abuse prevention while spending \$ 45.07 annually per resident child on child abuse. State spending on elder abuse had actually decreased 40% due to a corresponding decline in federal block grants."); see Velick, *supra* note 7, at 171 ("[W]ithout more federal funding, the states are 'severely hampered in channeling monies into this newly designated social services area -- elder abuse protective services -- on their own authority.'").

protecting the elderly.<sup>20</sup> By 1980, only sixteen states had mandated reporting statutes requiring certain professionals and personnel to report suspected elder abuse.<sup>21</sup> Today, every state but New York has mandatory reporting statutes in place.<sup>22</sup> However, while forty-nine states have mandatory reporting statutes, there is no uniform standard of penalties for failure to report elder abuse.<sup>23</sup>

In fact, despite the fact that every state has some sort of reporting statute, these statutes vary vastly from state to state. Elder abuse itself is defined differently from state to state. Furthermore, even in states that mandate reporting, there is a wide variance in the remedies presented for failing to report. Failure to report can range from a civil fine to a felony. In those states that treat failure to report as a criminal matter, statutes are widely unenforced,<sup>24</sup> and so do not actually create incentives to report elder abuse.<sup>25</sup> Additionally, while most states have statutes that direct individuals to report, only a handful of states take the responsibilities of institutions into account.<sup>26</sup> Given the importance of education and awareness of elder abuse and mandatory reporting, this seems to be an oversight that ought to be remedied.

This Note will examine state mandatory reporting statutes and the penalties they impose for failure to report suspected cases of elder abuse. Specifically, this Note will examine the differences between those states that impose criminal penalties for failure to report suspected cases of elder abuse, and those that impose civil penalties. El-

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20. Moskowitz, *supra* note 9, at 86.

21. *Id.* at 85.

22. Ryan Patrick Backer et al., *New York Doesn't Have Mandatory Reporting: Good or Something to Change?*, NYC ELDER ABUSE CTR., (Jan. 8, 2015), <http://nyceac.com/elder-justice-dispatch-new-york-state-doesnt-have-mandatory-reporting-good-or-something-to-change/> [hereinafter Backer].

23. Barber, *supra* note 11, at 119-20.

24. Barber, *supra* note 11, at 119-20, 126 (2008); see also Linda K. Chen, *Eradicating Elder Abuse in California Nursing Homes*, 52 SANTA CLARA L. REV. 213, 242 (2012) ("Some states have criminal penalties for mandated reporters that fail to report . . . Interestingly, doctors and other professionals are generally spared from the criminal sanctions and are merely referred to their respective professional organization for punishment . . . These criminal statutes, however, are rarely enforced due to a combination of lack of resources and the difficulty in elder abuse detection.") [hereinafter Chen].

25. Barber, *supra* note 11, at 120.

26. Laura Remick, *Penalties for Failing to Report Elder Abuse: Comparison Chart with Provisions From Adult Protective Services Laws, by State*, ABA COMMISSION ON LAW AND AGING (2009), [http://www.americanbar.org/content/dam/aba/administrative/law\\_aging/2011/2011\\_aging\\_ea\\_failure.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/law_aging/2011/2011_aging_ea_failure.authcheckdam.pdf) [hereinafter Remick].

der abuse encompasses a wide range of categories.<sup>27</sup> This Note will focus on mandatory reporting of physical and sexual abuse.<sup>28</sup> Since underreporting of elder abuse is such a serious problem, this Note will attempt to compare the effectiveness of criminal and civil penalties in incentivizing reporting of suspected elder abuse. In addition, this Note will address mandatory reporting laws with as they specifically relate to the needs and rights of the elder population.

Section II examines the development of mandatory reporting laws for elder abuse. Elder abuse laws were modeled after child abuse laws and have only recently been implemented. Section III will look at the effectiveness of criminal and civil penalties for mandated reporters who fail to report. In Part A, we will look at those states that treat failure to report elder abuse as a criminal matter. Part B will examine those states that impose civil penalties on mandated reporters who fail to report. Part C will discuss the Idaho statute regarding failure to report, in which institutions are held responsible when their employees fail to report elder abuse. Section IV will present a recommendation for effective mandated reporting laws. Finally, Section V will conclude.

## II. Background

The elderly population in the United States is a growing one. Thirteen percent of the population, or 40.3 million people, were people aged sixty-five or older according to the 2010 U.S. Census.<sup>29</sup> This population is expected to continue to grow. “By 2050, people age 65 and older are expected to comprise 20% of the total U.S. population.”<sup>30</sup> In fact, the elderly population is the fastest growing segment of the

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27. Laura Remick, *Failing to Report and False Reporting of Elder Abuse: Penalties Under State Adult Protective Services Laws*, 31 BIFOCAL 1, 10 (2009) (“According to the National Center on Elder Abuse, there are seven types of elder abuse. These include: (1) physical abuse . . . (2) sexual abuse . . . (3) emotional or psychological abuse . . . (4) neglect . . . (5) abandonment . . . (6) financial or material exploitation . . . and (7) self-neglect.”).

28. *Types of Elder Abuse*, NAT’L CTR. ON ELDER ABUSE (2007) <http://www.ncea.acl.gov/faq/abusetypes.html> (last visited Mar. 11, 2017) (Defining physical abuse as “the use of physical force that may result in bodily injury, physical pain, or impairment” and defining sexual abuse as “non-consensual sexual contact of any kind with an elderly person.”).

29. *Statistics/Data*, NAT’L CTR. ON ELDER ABUSE (2007), <https://ncea.acl.gov/whatwedo/research/statistics.html> (last visited Mar. 11, 2017) [hereinafter *Statistics/Data*].

30. *Id.*

population in the United States.<sup>31</sup> Problems facing this growing sector of the population are thus critical issues for our country.

It is estimated that there are nearly 1.5 million elderly people abused annually, and this number will continue to increase as the elderly population increases.<sup>32</sup> There are Adult Protective Services (APS) agencies in every state in the United States.<sup>33</sup> Forty-nine states have mandated reporting of elder abuse laws. Even so, the number of cases of elder abuse that go unreported every year is overwhelming. The National Elder Abuse Incidence Study (NEAIS) found that there are approximately five unreported instances of elder abuse for every reported instance of elder abuse.<sup>34</sup> Other studies have estimated that there are as many as twenty-four undetected cases of elder abuse for every case that is reported to an agency or service organization.<sup>35</sup>

Elder abuse comes in many different forms and takes place in many different settings. Experts believe that as wide-spread as elder abuse is, there are far more cases that go unreported and are never identified.<sup>36</sup> The NEAIS refers to this as the “iceberg” theory of elder abuse.<sup>37</sup> Aside from the directly negative effects, elder abuse leads to higher risk of death, risk of psychological distress, and increased health problems.<sup>38</sup> Furthermore, it is estimated that the elder abuse causes increased direct medical costs of \$5.3 billion to the annual health expenditures in this nation.<sup>39</sup> Identifying and preventing further cases of elder abuse would not only have profoundly beneficial effects on the elderly community, in terms of both health and emotional well-being, but it would also have very real economic benefits for the nation’s health care system.

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31. *Id.*

32. Moskowitz, *supra* note 9, at 87.

33. *Statistics/Data*, *supra* note 29.

34. See *The National Elder Abuse Incidence Study*, THE NAT’L CTR. ON ELDER ABUSE (Sept. 1998), [https://aoa.acl.gov/aoa\\_programs/elder\\_rights/ELDER\\_ABUSE/docs/ABuseReport\\_Full.pdf](https://aoa.acl.gov/aoa_programs/elder_rights/ELDER_ABUSE/docs/ABuseReport_Full.pdf) [hereinafter *National Elder Abuse Incidence Study*].

35. *Statistics/Data*, *supra* note 29.

36. *National Elder Abuse Incidence Study*, *supra* note 34, at 5-10.

37. *Id.* at 5-6.

38. See *id.*

39. See *Statistics/Data*, *supra* note 29.

### A. Elder Abuse in Facilities

There are close to four million Americans living in long term care facilities in the United States.<sup>40</sup> Of these four million, six out of seven are elderly, or sixty-five years or older.<sup>41</sup> It is estimated that over forty percent of the elderly population will end up in a nursing home before they die.<sup>42</sup> Unfortunately, elder abuse in these nursing homes is all too common. One study, in which two thousand nursing home patients were interviewed, found that forty-four percent of the residents interviewed had been abused and, disturbingly, ninety-five percent of those interviewed said they had seen another resident being abused or neglected.<sup>43</sup> During a two-year period, from 1999-2001, “[n]early 1 in 3 U.S. nursing homes were cited for violations of federal standards that had potential to cause harm or that had caused actual harm to a resident,” and “[n]early 1 out of 10 homes had violations that caused residents harm, serious injury, or placed them in jeopardy of death.”<sup>44</sup> Additionally, instances of elder abuse in nursing homes appear to be on the rise.<sup>45</sup>

Despite such extremely high rates of occurrence of elder abuse in these long-term care facilities, the pervasiveness of abuse is often downplayed or dismissed by those who run the facilities. A recent U.S. House of Representatives report on elder abuse in nursing homes found many “[c]ases where nursing homes ignored signs of serious abuse. In one instance, state inspectors asked about a female resident who appeared to have been sexually abused. The director of nursing replied, ‘maybe she fell on a broomstick.’”<sup>46</sup> Clearly, directors of nurs-

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40. *Abuse of Residents in Long Term Care Facilities*, NAT’L CTR. ON ELDER ABUSE (2013), [http://ddsn.sc.gov/providers/Documents/NCEA\\_LTCF\\_ResearchBrief\\_2013.pdf](http://ddsn.sc.gov/providers/Documents/NCEA_LTCF_ResearchBrief_2013.pdf) [hereinafter *Abuse of Residents*].

41. *See id.*

42. *Id.*

43. *Id.*

44. *Id.* at 1.

45. *Abuse of Residents Is a Major Problem in U.S. Nursing Homes*, U.S. HOUSE OF REP. REPORT 6 (July 30, 2001), <http://canhr.org/reports/2001/abusemajorproblem.pdf> (“The percentage of nursing homes cited for abuse violations during annual state inspections has almost tripled since 1996. In 1996, 5.9% of all nursing homes were cited for an abuse violation during their annual inspections. The percentage of homes cited for abuse violations has risen in each successive year. In 2000, 16.0% of nursing homes were cited for an abuse violation during their annual inspections.”).

46. *Id.* at ii.

ing homes are not responding appropriately considering the severity of the problem.<sup>47</sup>

While abuse occurs at high rates, in nursing homes and other long-term care facilities, reports of abuse seem to occur at much lower rates.<sup>48</sup> In many incidents, abuse is only discovered when a formal complaint is made.<sup>49</sup> However, formal complaints are not filed in many cases of resident abuse.<sup>50</sup> Complaints are generally filed by family members or other parties outside of the nursing home. Given that that so many violations are only uncovered through investigations prompted by formal complaints (made by outside parties), it is clear that nursing home staff are not adequately reporting or investigating instances of elder abuse.<sup>51</sup> Abuse is not being reported or investigated unless there are outside observers involved.<sup>52</sup>

In fact, a report to the U.S. House of Representatives found that “[t]he most frequent abuse violation was the failure to properly investigate and report allegations of resident abuse, neglect, or mistreatment or to ensure that nursing home staff do not have a documented history of abusing, neglecting, or mistreating residents.”<sup>53</sup> The report found that over a two-year period, 3,797 nursing homes were given citations for failure to properly report or investigate abuse, neglect, or mistreatment of elders.<sup>54</sup> Failure to report or appropriately investigate was the most prevalent violation over the course of the study.<sup>55</sup> The second most common violation was closely related. Developing protocols and written policies prohibiting abuse and other forms of mal-

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47. *See id.* (showing numerous instances where nursing home directors failed to respond adequately, and in some cases simply did not investigate instances of elder abuse perpetrated by staff members or other residents).

48. *Id.* at 8 (“Because formal complaints are not filed for many cases where residents are abused, it is likely that the incidence of abuse is even higher than indicated in this study.”).

49. *Id.* (“In addition to the general problems of underreporting identified by GAO, researchers have reported that abuse cases are especially likely to go undetected or unreported. Almost 40% of the abuse violations identified in this report were discovered after the filing of a formal complaint.”).

50. *Id.*

51. *Id.* at 5-6 (“[I]f a resident, a resident’s family, or another member of the community files a complaint about substandard care in a nursing home, the state must investigate that complaint. The data obtained from HCFA indicates that many abuse cases are uncovered only during these complaint investigations.”).

52. *Id.*

53. *Id.* at 5

54. *Id.*

55. *See id.* at 8.

treatment of residents<sup>56</sup> was the second most common violation, according to the report, with 2,314 nursing homes receiving citations for this offense over the two-year study period.<sup>57</sup> Clearly, abuse is occurring in nursing homes, yet reporting and adequate procedures for investigating, preventing, and redressing this abuse have not yet been developed or put in place in the vast majority of these long term care facilities. In order to do an adequate job of caring for their elderly populations, these facilities need to develop practices that can address this problem.

### B. Elder Abuse in the Home

A large percentage of elder abuse is perpetrated by family members of the victims themselves.<sup>58</sup> In fact, the NEAIS found that adult children were the most often reported alleged abusers of the elderly,<sup>59</sup> although other studies have pointed to spouses, as well as adult children, as the main perpetrators of elder abuse in the home.<sup>60</sup> Because elders are so frequently cared for by their own family members, the high proportion of perpetrators who are family members makes sense.<sup>61</sup>

As is the case with elder abuse that occurs in care facilities, elder abuse that occurs in the home is often widely underreported.<sup>62</sup> This is often exacerbated by the fact that the victims of elder abuse in domestic situations are isolated and do not often interact with outside

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56. *Id.* ("The second most common abuse violation was the failure to develop and implement written policies that prohibit abuse, mistreatment, and neglect of residents and the misappropriation of residents' property.").

57. *Id.*

58. *National Elder Abuse Incidence Study*, *supra* note 34, at 5-6. ("Relatives or spouses of the victims commit most domestic elder abuse according to reports supplied both by APS and sentinels. Approximately 90 percent of alleged abusers, according to both types of sources, were related to victims. APS data suggest that adult children are the largest category of abusers, across all forms of abuse . . . . Adult children also account for the largest category of alleged abusers in sentinel reports (39 percent). Since family members are frequently the primary caregivers for elderly relatives in domestic settings, this finding that family members are the primary perpetrators of elderly abuse is not surprising.")

59. *Id.* ("Adult children also account for the largest category of alleged abusers in sentinel reports.").

60. Moskowitz, *supra* note 9, at 87; *see also* Karl Pillemer & J. Jill Suito, *Violence and Violent Feelings: What Causes Them Among Family Caregivers?*, 47 J. OF GERONTOLOGY S165, S170 (1992) ("Being a spousal caregiver rather than another relative was a very strong predictor of actual violence.").

61. *National Elder Abuse Incidence Study*, *supra* note 34, at 5-6.

62. *Statistics/Data*, *supra* note 29.

parties who could report the abuse.<sup>63</sup> When elders do interact with outside care professionals, it is critical that the professionals have training on how to detect and report elder abuse, because if they do not, then the abuse goes undetected and unreported.<sup>64</sup> “[E]lder abuse thrives on total isolation—it is a ‘secret crime.’ Therefore, when people do spot a victim, it is crucial that they report the suspected abuse . . . because another opportunity to address the problem may not arise.”<sup>65</sup> Underreporting is thus an even more serious issue in the context of elder abuse that occurs specifically within the confines of the victim’s home, because opportunities for detection and reporting of abuse by outside people are so few.

Frequently, the victims themselves will not report the abuse. Because the perpetrators are so often family members, especially children or spouses,<sup>66</sup> the victims of abuse are reluctant to report because they do not want to get their family members in trouble.<sup>67</sup> Victims of elder abuse may also not want to report abuse because they may fear retaliation from their caregiver or abuser.<sup>68</sup> In cases where the abuser is the sole or primary caregiver, this is an especially salient fear.<sup>69</sup> Furthermore, some victims may be physically or mentally unable to report their abuse.<sup>70</sup> Because elders abused in the home have many limitations preventing them from being able to report their own abuse, reporting of elder abuse by the few health care professionals with whom these victims may have the chance to interact with becomes an absolutely critical facet of detecting, preventing, and punishing elder abuse.

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63. *Id.*

64. Velick, *supra* note 7, at 174.

65. *Id.*

66. *Statistics/Data*, *supra* note 29.

67. *Id.*

68. *Id.*

69. See Barber, *supra* note 11, at 124-25 (describing the relationship between the abuser and the victim as one similar to that in domestic violence situations, where the victim may be hesitant to report his abuser due to “power and control, denial, family and economic reasons, and emotional attachment.” Additionally, “[w]hen the abuser is a family member, the victim may feel the judgment of the rest of the family and society in addition to internal feelings of guilt. Emotional attachment is also common when the abuser is a relative or close friend. The victim may feel a sense of protection in the presence of the abuser as a result of the relationship.”).

70. *Statistics/Data*, *supra* note 29.

### C. Mandated Reporting Laws

Laws about elder abuse generally, and mandated reporting laws specifically, were primarily modeled after child abuse statutes.<sup>71</sup> As such, they are not always responsive to the needs of the elderly population specifically.<sup>72</sup> While the state presumes responsibility for protecting children and routinely makes decisions on their behalf, adults are presumed to be capable of making their own decisions and have the right to make bad decisions.<sup>73</sup> For the most part, current elder abuse laws, specifically the mandated reporting laws, do not leave much leeway for the victim's capacity to make their own decisions. In some cases, mandatory reporting may even call for doctors or other health professionals to report an individual for elder abuse against the elder person's wishes.<sup>74</sup> Critics of mandated reporting deride it for intruding on elderly people's privacy and right to determine what should happen in their own life.<sup>75</sup>

Currently all fifty states have some sort of statutes that govern the reporting of elder abuse.<sup>76</sup> These statutes generally fall within three categories. States' statutes require either mandatory reporting, limited mandatory reporting, or voluntary reporting.<sup>77</sup> The majority of states fall within the mandatory reporting category. "Mandatory reporting laws require all people or specific categories of professionals to report

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71. Nancy Coleman & Naomi Karp, *Recent State and Federal Developments in Protective Services and Elder Abuse*, 1 J. OF ELDER ABUSE & NEGLECT 51, 53 (1989) [http://www.americanbar.org/content/dam/aba/administrative/law\\_aging/2011\\_aging\\_arta2250\\_rcntdvlea\\_fb.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/law_aging/2011_aging_arta2250_rcntdvlea_fb.authcheckdam.pdf) [hereinafter Coleman].

72. See *id.* at 51, 53-54; see also *National Elder Abuse Incidence Study*, *supra* note 34, at 5-3 ("Overall, elder abuse is even more difficult to detect than child abuse, since the social isolation of some elderly persons may increase both the risk of maltreatment itself and the difficulty of identifying that maltreatment. Approximately a quarter of elders live alone, and many others interact primarily with family members and see very few outsiders. Children, in contrast, never live alone and, furthermore, are required by law to attend school from age 5 until 16 . . . . Although community sentinels are valuable sources of information about abuse and neglect of elders, neither they nor other reporting sources can conclusively account for victims of domestic abuse and neglect who do not leave their homes and who rarely come in contact with others. Consequently, the NEAIS undoubtedly undercounts abuse, neglect, and self-neglect among isolated elderly people in domestic settings.").

73. Coleman, *supra* note 71, at 51, 53.

74. Laurence R. Faulkner, *Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults*, 16 FAM. L. Q. 69, 83-84 (1982) [hereinafter Faulkner].

75. *Id.* at 85-86.

76. U.S. GOV'T ACCOUNTABILITY OFF., GAO/HRD-91-74, *Elder Abuse: Effectiveness of Reporting Laws and Other Factors*, 1, 1-2 (1991).

77. *Id.*

known and suspected incidents to certain authorities. Under voluntary reporting laws, no one is *required* to report, but any person *may* report incidents of elder abuse."<sup>78</sup>

Since there are no overarching laws governing mandated reporting and elder abuse, states have developed their own laws addressing the issue of reporting elder abuse. Some states impose criminal liability for failure to report elder abuse, and others impose civil liability.<sup>79</sup> Among the states that impose criminal liability, some states treat failure to report as a misdemeanor, while others treat it as a felony.<sup>80</sup> Civil penalties may be imposed on the individual responsible for reporting. However in some states, institutions are held responsible for their employees' failure to report elder abuse.<sup>81</sup> New York is currently the only state that does not have mandated reporting and instead relies on voluntary reporting.<sup>82</sup>

Both states that impose criminal penalties and states that impose civil penalties for failure to report suspected cases of elder abuse face the criticism that requiring mandatory reporting impinges on the elderly victims rights and privacy.<sup>83</sup> However, while it is important to respect the privacy and autonomy of the elderly, it is also important to combat underreporting of elder abuse. Mandated reporting statutes were originally enacted as a means of increasing reporting of child abuse. However, children lead different lives. On a daily basis, children are in contact with a variety of adults, from day care personnel to doctors to teachers and others. By contrast, many of the most vulnerable elder people are far more isolated. In fact, on a daily basis, an elderly person's only point of contact may be their abuser. When an outside person does see or suspect abuse, it becomes absolutely critical that they report the abuse, as there may not be any others checking on the elder.<sup>84</sup>

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78. *Id.*

79. Nina A. Kohn, *Outliving Civil Rights*, 86 WASH. U. L. REV. 1053, 1061-62 (2009) ("[S]tates vary in the consequences they impose on those who fail to fulfill their duty to report. In most states, such failure is a misdemeanor. In some of these, the penalty for the misdemeanor of failure to report is exclusively a monetary fine. In other states, jail time may be imposed. A few states also allow it to be the basis for imposition of civil liability. Finally, failure to report may have licensure implications for certain professionals.") [hereinafter Kohn].

80. Remick, *supra* note 26.

81. IDAHO CODE ANN. § 39-5303 (West 2016).

82. See Backer, *supra* note 22.

83. See generally Kohn, *supra* note 79.

84. Velick, *supra* note 7, at 174 ("[E]lder abuse thrives on total isolation – it is a 'secret crime.' Therefore, when people do spot a victim, it is crucial that they report

Underreporting is a significant problem in combatting elder abuse. In addition, when elder abuse is reported, it is often not done in a timely fashion. In the example of Mr. Mathis, the nursing home staff eventually made a report, but only after the abuse had been an ongoing pattern for quite some time.<sup>85</sup> This appears to be a widespread problem. In its report to Congress, the GAO found that reports about elder abuse are often made days, or even weeks, after the actual abuse occurred.<sup>86</sup> In fact, of the cases the GAO assessed, in approximately twenty-five percent of the cases, the report was submitted more than two weeks after the abuse occurred, even though the state required that agencies report instances of alleged abuse within a day of learning about the alleged instance.<sup>87</sup> Such delays in reporting compromise the evidence and increase the difficulty of successfully prosecuting abusers.<sup>88</sup> In its study, the GAO found a correlation between states with better rates of reporting and more effective investigations of elder abuse.<sup>89</sup>

### III. Analysis

While victims are often reticent to bring charges against their abuser, if there is a mandatory reporting statute, then some of the pressure is taken off of the victim. Elder abuse is often perpetrated by the victim's caretaker, who may even be a family member.<sup>90</sup> In such situations, the elder victim may want to protect their abuser at great personal risk.<sup>91</sup> A survey by the California Department of Social Services showed that eighty-five percent of abuse victims would accept

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the suspected abuse . . . the physician, or any other professional who suspects abuse, should not be required to report it because another opportunity to address the problem may not arise.”).

85. See Lew, *supra* note 1, at 7-8.

86. U.S. GEN. ACCOUNTING OFF., GAO-02-312, NURSING HOMES: MORE CAN BE DONE TO PROTECT RESIDENTS FROM ABUSE 10 (2002).

87. *Id.* at 10-11.

88. *Id.* at 14.

89. *Id.* at 15.

90. Velick, *supra* note 7, at 174-75 (“[A] number of elder-abuse victims actually assisted their abusers with cooking, cleaning, housing, and transportation. The victims were reluctant to acknowledge or to report the abuse because they were unwilling to leave the abuser without adequate care. Apparently, families try to stick together. . . . Mandatory reporting can bypass this misplaced concern about family members, which may take precedence over the victim's own well-being. Mandatory reporting also addresses situations in which victims are dependent on their families for care.”).

91. *Id.*

help with dealing with abuse.<sup>92</sup> Thus, it is likely that if victims are put into contact with victim aid services, then they will accept that help. Mandated reporting would facilitate this because the victim would not be responsible for the report made against the perpetrator. In a sense, “the reporter can give the victim an out by asserting that the report is required by law. Reporters and even victims can say to themselves, ‘It is not me. I have to do this.’”<sup>93</sup> In cases where the reporter would face criminal charges for not reporting, this could allow some relief to the victim who could think of it as a procedure enforced by the law, rather than the victim feeling responsible for turning the perpetrator in. Thus, effective mandating reporting laws are a critical component of adequately addressing the problem of elder abuse. Mandated reporting laws ensure that more elder victims are given access to victim aid services. They also ensure that law enforcement are given timely and accurate reports of alleged elder abuse. Collectively, victims are given more aid and abusers face justice more often.

#### A. Criminal Penalties for Failure to Report

The majority of states treat failure to report as a criminal, rather than civil, matter.<sup>94</sup> Usually, states that treat failure to report as a criminal matter penalize the failure as a misdemeanor.<sup>95</sup> Imposing criminal penalties for failing to report elder abuse emphasizes the seriousness of the not reporting. Given that elder abuse is so underreported, treating failures to report seriously should be a priority.<sup>96</sup> However, there are some serious problems with treating failure to report as a criminal matter. In states where failure to report is a criminal matter, enforcement of mandated reporting laws is very low and sometimes even nonexistent.<sup>97</sup> For example, in California, failure to report physical elder abuse is a misdemeanor.<sup>98</sup> However, there has been little to no

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92. *Id.* at 175.

93. *Id.*

94. Moskowitz, *supra* note 9, at 117.

95. Barber, *supra* note 11, at 119-20.

96. See Velick, *supra* note 7, at 167-68.

97. Moskowitz, *supra* note 9, at 117.

98. See CAL. WELF. & INST. CODE § 15630.1(h) (“Failure to report, or impeding or inhibiting a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars (\$1,000), or by both that fine and imprisonment. Any mandated reporter who willfully fails to report, or impedes or inhibits a report of, physical abuse, as defined in

prosecution of failure to report elder abuse.<sup>99</sup> In fact, “[b]etween 1993 and 2004, district attorneys prosecuted only forty-six cases for the failure to comply with the Mandated Reporting Act.”<sup>100</sup> In part, this is due to reluctance on the part of prosecutors to bring criminal sanctions against white-collar professionals, such as doctors and other professionals.<sup>101</sup>

Additionally, after *Crawford v. Washington*, it became more difficult to prosecute abuse.<sup>102</sup> *Crawford* held that it was unconstitutional to use a videotape or prerecorded statement by victims or witnesses because it would deny the defendant the right to confront his or her accusers.<sup>103</sup> This is a particularly burdensome limitation in the context of elder abuse because the victims and witnesses are often frail or in poor health or may simply not be around when the case goes to trial. If a key witness’s testimony is barred by this rule, the criminal prosecution may fail.<sup>104</sup>

In California, failure to report elder abuse is treated as a criminal offense. Under Cal. Wel. & Inst. Code § 15630 (h), failure to report elder abuse is a misdemeanor and “shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars (\$5,000), or by both that fine and imprisonment.”<sup>105</sup> While this statute appears to indicate that the California legislature considers the problem of failure to report to be a serious one, studies indicate that

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Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, if that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars (\$5,000), or by both that fine and imprisonment.”).

99. Moskowitz, *supra* note 9, at 117 (“Few actual cases of prosecution against professionals can be found. A computer search of published court decisions in all fifty states between 1994-1997 found only one prosecution based on a failure to report elder mistreatment statute, and even that case did not directly involve a failure to report.”).

100. Chen, *supra* note 24, at 242.

101. Barber, *supra* note 11, at 120 (“Interestingly, doctors and other professionals are generally spared from the criminal sanctions and are merely referred to their respective professional organization for punishment.”); Moskowitz, *supra* note 9, at 119 (“Even when they do become aware, prosecutors are loathe to proceed against white collar professionals.”).

102. See generally Lew, *supra* note 1, at 18; see also *Crawford v. Washington*, 541 U.S. 36 (2004).

103. Lew, *supra* note 1, at 19.

104. *Id.*

105. CAL. WELF. & INST. CODE § 15630 (2014).

the mandated reporters rarely comply with the statute.<sup>106</sup> In fact, even though California's mandated reporting statutes place serious penalties on those who fail to report, "many abuse citations are triggered by public complaints rather than by facility reports."<sup>107</sup> It appears that within California care facilities, while abuse occurs at high rates, and is often readily apparent to, or even actually observed by, the health care professionals working in those care facilities (who are mandated reporters), reports are not being made or investigated unless if outside parties bring attention to allegations.<sup>108</sup> The penalties attached to failure to report are not sufficiently incentivizing health care professionals to report abuse.

Underreporting of elder abuse remains a problem in care facilities in California even with the harsh penalties available for those who fail to report.<sup>109</sup> In fact, there is "a cultivated culture of silence amongst facility employees"<sup>110</sup> that ensures elder abuse goes unreported. Even in instances where victims or outside parties (such as other family members) are able to speak out and make complaints about abuse, their complaints are often silenced and are not registered as official reports.<sup>111</sup> While investigating a complaint that a CNA "hit a ninety-eight-year-old resident in the face, bruising her face and hurting her eye,"<sup>112</sup> the California Department of Health Services found that "[t]he facility administrator did not report the abuse despite the resident's injury and multiple complaints from family members that the alleged perpetrator mistreated other residents. The administrator merely moved the perpetrator to another assignment."<sup>113</sup>

Incidents of administrators minimizing or covering up abuse allegations occur far too frequently in California care facilities.<sup>114</sup> Ac-

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106. Moskowitz, *supra* note 9, at 611 ("Unfortunately, there is much evidence to indicate that mandated reporters rarely comply. Many studies report that these statutes are ignored.").

107. *Nursing Home Abuse and California's Broken Enforcement System*, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM 2 (2006), [http://www.canhr.org/reports/2006/Abuse\\_Report\\_2006\\_solo.pdf](http://www.canhr.org/reports/2006/Abuse_Report_2006_solo.pdf) [hereinafter *Nursing Home Abuse*].

108. *Id.* at 4.

109. Chen, *supra* note 24, at 219 ("Underreporting by nursing homes contributes to the continued abuse of our elderly.").

110. *Id.*

111. See *Nursing Home Abuse*, *supra* note 107.

112. See *id.*

113. *Id.*

114. Chen, *supra* note 24, at 241; see also *Nursing Home Abuse*, *supra* note 107, at p2 ("In some nursing homes, the administrator and operator cultivate a culture of

ording to the California Advocates for Nursing Home Reform, "abuse citations appear to indicate endemic or habitual behavior, rather than isolated incidents."<sup>115</sup> While California's laws require reports to be made within two days of learning about the suspected abuse, within care facilities, abuse allegations are frequently carried up the administrative chain, rather than being dispatched to the appropriate investigative authorities in a timely fashion.<sup>116</sup> "Nursing home staff often report an abuse incident internally up the chain of command within the facility rather than simultaneously reporting to outside investigators."<sup>117</sup> This practice does not meet the requirements of California's mandatory reporting laws, and furthermore, often impedes the investigation of claims, specifically because administrative employees frequently minimize or misconstrue aspects of the abuse in an effort to protect their facility.<sup>118</sup> In addition to concerns about protecting the facility, nursing home staff may hesitate to make reports about their fellow colleagues.<sup>119</sup> While the California statute contemplates the seriousness of a failure to report suspected elder abuse, within nursing homes across California, abuse is not being reported to the appropriate investigatory channels, and consequently, elder victims are subjected to more abuse.

These delays and blatant disregard for the mandated reporting procedures set out by the California Code cause very real damage to California's elderly population. Given the seriousness of the issue, it is critical that mandated reporting laws be fully enforced. However there is a clear discrepancy between very high levels of under or de-

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silence that encourages employees to ignore incidents of abuse. This culture is so pervasive that the California Court of Appeals took judicial notice of it recently.").

115. *Nursing Home Abuse*, *supra* note 107.

116. Chen, *supra* note 24, at 241-42 (While the Mandated Reporting Act requires that nursing homes make a telephone report of suspected elder abuse immediately and a written report within two days, "[n]ursing homes, however, often do not follow this time requirement, blatantly ignoring the law.").

117. Lew, *supra* note 1, at 7.

118. Chen, *supra* note 24, at 242 ("Administrators do not have direct experience with the alleged abuse and have an interest in minimizing the severity of the incident as an employee of the facility. They may misconstrue facts or be reluctant to reveal critical details to protect the nursing home from liability.").

119. Arlene D. Luu & Bryan A. Liang, *Clinical Case Management: A Strategy to Coordinate Detection, Reporting and Prosecution of Elder Abuse*, 15 CORNELL J. L. & PUB. POL'Y 165, 176 (2005) ("Although a willful failure to report patient abuse is prohibited, nursing home employees are often reluctant to report their colleagues for committing acts of abuse.").

layed reporting and the low levels of prosecution for failure to comply with mandated reporting laws.<sup>120</sup>

In some states (California, Indiana, Florida, Connecticut, and Alaska) failure to report elder abuse has harsher penalties than elder abuse itself.<sup>121</sup> Penalties for failure to report a suspected case of elder abuse should not be harsher than penalties for the actual perpetrator of the abuse.

### B. Civil Penalties for Failure to Report

Other states (Arkansas, Iowa, Michigan, and Minnesota) impose civil liability for failure to report elder abuse.<sup>122</sup> Among those states that impose civil liability, failure to report elder abuse can result in fines for the individual.<sup>123</sup> For example, in Michigan, failure to report elder abuse can result in a fine of \$500 for each failure to report.<sup>124</sup> Civil remedies, such as those provided for in Michigan, present several advantages over criminal remedies. First and foremost, having civil remedies removes the reluctance to prosecute professionals.<sup>125</sup> Second, the civil process typically moves much faster than the criminal process, which means that victims are much more likely to receive compensation for their harm.<sup>126</sup> Third, the lower burden of proof in the civ-

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120. Chen, *supra* note 24, at 242.

121. Coleman, *supra* note 71.

122. See ARK. CODE ANN. § 5-28-202(b) (Mich. 1997 & Supp. 2001) ("Any person or caregiver required by this chapter to report a case of suspected abuse, neglect, or exploitation who purposely fails to do so shall be civilly liable for damages proximately caused by the failure."); IOWA CODE ANN. § 235B.3(10) (West 2000 & Supp. 2002) ("A person required by this section to report a suspected case of dependent adult abuse who knowingly fails to do so is civilly liable for the damages proximately caused by the failure."); MICH. COMP. LAWS § 400.11e(1) (2001) ("A person required to make a report pursuant to section 11a who fails to do so is liable civilly for the damages proximately caused by the failure to report, and a civil fine of not more than \$500.00 for each failure to report."); MINN. STAT. ANN. § 626.557(7) (West 1983 & Supp. 2002) ("A [mandated reporter] who negligently or intentionally fails to report is liable for damages caused by the failure."); Remick, *supra* note 26 ("In Arkansas, Iowa, Michigan, and Minnesota, mandated reporters may face civil liability for the damages incurred by victims due to their failure to report.").

123. Remick, *supra* note 26, at 5.

124. MICH. COMP. LAWS § 400.11e ("A person required to make a report pursuant to section 11a who fails to do so is liable civilly for the damages proximately caused by the failure to report, and a civil fine of not more than \$500.00 for each failure to report.").

125. See generally Remick, *supra* note 26.

126. *Id.*

il process and the ease of discovery means that it is all the more likely that civil prosecution will be more successful.<sup>127</sup>

Other states have not been so forthcoming with guidance as to the specific remedies. In Minnesota, “[a] mandated reporter who negligently or intentionally fails to report is liable for damages caused by the failure.”<sup>128</sup> In Iowa, the statute merely provides that “[a] person required by this section to report a suspected case of dependent adult abuse who knowingly fails to do so or who knowingly, in violation of subsection 3, interferes with the making of such a report, or applies a requirement that results in such a failure is civilly liable for the damages proximately caused by the failure.”<sup>129</sup>

The Iowa code appears to have had some efficacy, at least in encouraging employees to report suspected cases of elder abuse. Although use of the mandated reporting statute has been limited as a means of prosecuting those who fail to report, it has been effective at protecting health care professionals who were penalized by their institutions for reporting suspected elder abuse.<sup>130</sup> In *Rivera v. Woodward Res. Ctr.*, the Iowa Court of Appeals cited IA ST § 235B in its determination that reporting suspected abuse was “protected activity,”<sup>131</sup> and thus an employee could not be penalized for having reported.

### C. Penalties Against Institutions

While over 1.7 million Americans currently reside in nursing homes, the quality of care in those nursing homes varies vastly. As in the case of Mr. Matthis, the care received in those nursing facilities is, at times, unacceptable. In order to rectify this, institutions and facilities themselves should be held directly responsible, rather than the individual workers within the institution. Fining facilities, rather than individuals for failure to report would be a more effective way to combat underreporting of elder abuse.<sup>132</sup>

California currently treats failure to report as a criminal matter.<sup>133</sup> However, while this allows for a high level of prosecution

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127. *Id.*

128. MINN. STAT. ANN. § 626.557 (2016).

129. IOWA CODE ANN. § 235B.3 (2016).

130. *See generally id.*

131. *See generally* *Rivera v. Woodward Res. Ctr.*, 865 N.W.2d 887 (Iowa 2015).

132. Remick, *supra* note 26, at 10.

133. *Your Legal Duty... Reporting Elder and Dependent Adult Abuse*, ATTORNEY GENERAL'S CRIME OFFICE 6, [http://oag.ca.gov/sites/all/files/agweb/pdfs/bmfea/yld\\_text.pdf](http://oag.ca.gov/sites/all/files/agweb/pdfs/bmfea/yld_text.pdf).

against individuals who fail to make reports of elder abuse, there is a widespread failure to report that occurs specifically within institutions. Currently, reporting is the individual's duty.<sup>134</sup> This means that a mandated reporter cannot hand the responsibility of making the report over to a different staff member, such as a supervisor.<sup>135</sup> However, in reality, this exact situation appears to be a problem. Studies have shown that many physicians and other health care professionals who work in institutions do not follow mandatory reporting laws and in some cases are either unsure of what the laws are or are simply unaware of the laws.<sup>136</sup>

The Idaho legislature has enacted statutes that address this specific problem. In Idaho, failure "to report abuse or sexual assault that has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult as provided under this section"<sup>137</sup> gives the department license to levy a variety of different responses against the institution. For instance, the department may choose to "[r]evoke the facility's license,"<sup>138</sup> or "close the facility,"<sup>139</sup> or "[r]educe the licensed bed capacity,"<sup>140</sup> or even to "[b]an all admissions to the facility."<sup>141</sup> By levying penalties against the institution, the provision places responsibility squarely on the shoulders of the institution, and it also allows a variety of different responses that can be tailored to fit a particular institution.<sup>142</sup> For jurisdictions such as California, where there has been documented evidence that the problem of failure to report elder abuse is specific to certain institutions, this kind of solution makes much more sense. Rather than placing the

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134. *Id.*

135. *Id.*

136. Velick, *supra* note 7, at 181 ("A recent North Carolina study reinforced this conclusion when it found that eighty percent of the doctors interviewed did not know there was a state law requiring them to report abuse."); see R. Stephen Daniels et al., *Physician's Mandatory Reporting of Elder Abuse*, 29 *THE GERONTOLOGIST* 321, 325 (1989) (Sixty percent of Alabama physicians were unaware or uncertain of reporting procedures for elder abuse);

Dorrie E. Rosenblatt et al., *Reporting Mistreatment of Older Adults: The Role of Physicians*, *J. AM. GERIATRICS SOC'Y* 65, 65-66 (1996); see also Carolyn Lea Clark-Daniels et al., *Abuse and Neglect of the Elderly: Are Emergency Department Personnel Aware of Mandatory Reporting Laws?*, 19 *ANNALS OF EMERGENCY MED.* 970 (1990) [hereinafter Clark-Daniels].

137. IDAHO CODE § 39-5303 (2) (2016).

138. IDAHO CODE § 39-5303 (2)(a) (2016).

139. IDAHO CODE § 39-5303 (2)(e) (2016).

140. IDAHO CODE § 39-5303 (2)(j) (2016).

141. IDAHO CODE § 39-5303 (2)(h) (2016).

142. See generally IDAHO CODE § 39-5303(2) (2016).

blame on certain individuals, it moves the blame to institutions. Additionally, the responses are tailored to force the institutions to adequately address reporting issues in a timely manner.

In situations like these, placing the responsibility on the institution makes much more sense than blaming the individual for two reasons. First, individuals within the institution may have tried to report, but if their supervisors have not put reporting procedures in place or informed their workers of the need to report, then the report may have gone no further than the supervisor. In such instances, the institution, not the individual should be held responsible, because the institution is responsible for putting in place procedures that are not conducive to reporting elder abuse.<sup>143</sup> In fact, “[m]any medical professionals are either unaware of state mandatory reporting laws or choose to disregard them.”<sup>144</sup> Getting rid of the individual worker, who may have even made some effort to report, will not change the fact that there are no procedures in place at that institution for reporting elder abuse.

Holding the institution responsible would create an immediate incentive to put better reporting procedures in place. For example, under the Idaho statute, if a mandated worker at a particular institution failed to report elder abuse, that institution could be held responsible and the facility’s license could be revoked, they could be denied payment, or they could be given a monetary fine.<sup>145</sup> Revoking a facility’s license would force the facility to address issues of reporting failures. The alternative, contracting with the state to provide services, would help to ensure a uniform response across the state.<sup>146</sup> In fact, any of those remedies would create immediate financial incentive to make the process of reporting clear to the workers in the facility.

Creating incentives for institutions to train and educate their workers would be the most effective means of increasing reporting rates of elder abuse. A 1998 plan implemented by the District Attorney in Middlesex County, Massachusetts demonstrated the effectiveness of institutional training and education, rather than imposing

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143. Velick, *supra* note 7, at 181 (“It’s easy to blame physicians, but someone has failed to inform them and those adult protective service people of the law.’ Before reporters can report abuse, they must know how to recognize abuse, that they are required to make the reports, and how reports are made.”).

144. Clark-Daniels, *supra* note 136, at 970.

145. See generally IDAHO CODE § 39-5303(2) (2016).

146. Velick, *supra* note 7, at 181.

finer on individuals, in increasing rates of reporting elder abuse.<sup>147</sup> In Middlesex, the District Attorney's office trained hospital and clinic staff, police, and protective service workers in signs of elder abuse and procedures for when and how to report elder abuse.<sup>148</sup> Prior to the training, the hospital and clinic staffs rarely reported elder abuse, even though they were, by law, mandatory reporters.<sup>149</sup> After the training on Massachusetts mandatory reporting laws, elder abuse reports increased by 350%.<sup>150</sup> Clearly, providing training and education regarding mandated reporting is an effective way to increase reporting of elder abuse. Criminalizing failure to report simply does not provide an effective means of educating professionals on mandated reporting. However, civil fines levied against institutions would provide a strong incentive for those very institutions to train and educate their employees. Given the importance of awareness of elder abuse and mandatory reporting laws, statutes should encourage institutions such as hospitals and clinics to educate their professionals rather than providing for under-enforced penalties against individuals.<sup>151</sup>

#### D. Addressing Other Critiques of Mandatory Reporting

Statutes mandating reporting of elder abuse were based on child abuse statutes. However, some question whether mandatory reporting laws, which may be appropriate for child abuse, are an appropriate means of combating elder abuse.<sup>152</sup> Critics deride mandatory reporting statutes for inappropriately dispensing with elderly peo-

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147. *Id.* ("Objective evidence is now available to confirm that connection. There was a 350% increase in elder-abuse reports from 1987 to 1989 when a program in Middlesex County, Massachusetts provided special training on the state's mandatory abuse reporting law.").

148. Velick, *supra* note 7, at 182 (1995).

149. *Id.*

150. *Id.* at 181.

151. *See id.* at 182 (indicating that the American Medical Association, American Medical News, and other medical organizations say that awareness of mandatory reporting laws is key to combating elder abuse); *see also* Moskowitz, *supra* note 9, at 119 (criminal penalties against white-collar professionals are rarely enforced); Barber, *supra* note 11, at 120 (reporting under enforcement of criminal statutes for failure to report when the reporters are doctors or other professionals).

152. Faulkner, *supra* note 74, at 75 ("The provision for mandated reporting of cases of suspected child abuse has thus been a part of the 'solution' to the problem of child abuse since the initial legislation. The question to be addressed is whether or not mandatory reporting, an integral part of the child abuse model, is transferable to cases of suspected elder abuse, and, even if effective, should it be applied to mature adults?").

ple's privacy and autonomy.<sup>153</sup> Mandatory reporting of child abuse was developed, in part, because the state has a parental duty towards children, as they cannot always speak for themselves.<sup>154</sup> However, when mandatory reporting is used in the context of elder abuse, it becomes problematic.<sup>155</sup> While the state is given broad leeway in protecting the best interests of children, elderly persons are adults and are presumed to be capable of making their own decisions, regardless of whether those decisions comport with their best interest.<sup>156</sup> In states where self-neglect is considered elder abuse, mandatory reporting statutes can be especially problematic. "Mandatory elder abuse reporting laws exist to protect older individuals who are unable to protect themselves from infliction of harm, and to protect society against wrongdoers who inflict the harm . . . . Self-neglect by a competent older person, however, does not fall within this scope of conduct warranting government intervention. Government intervention should not result merely from a lucid individual's choice that deviates from a 'normal' course of action, even if that choice seems detrimental to the decider."<sup>157</sup> Balancing the interest in protecting an elder person from abuse against that of protecting the autonomy and sense of self-worth of elderly individuals is a difficult decision for any health profession-

153. See generally Dyana Lee, Note, *Mandatory Reporting of Elder Abuse: A Cheap but Ineffective Solution to the Problem*, 14 FORDHAM URB. L.J. 723 (1986).

154. Faulkner, *supra* note 74, at 76, 82 ("The basic assumption of mandatory reporting statutes is that children and other 'incompetents' cannot speak for or protect themselves . . . . Unlike the mature adult, a child cannot decide when best to exercise the privilege and when to give a doctor permission to abrogate it. The privilege of confidentiality is designed to protect the patient, and it would certainly be unjust if the perpetrator of abuse against a patient (child) could use the privilege to protect himself/herself from prosecution. When the child is the patient, the privilege is the child's and confidentiality is not breached if the doctor reports suspected abuse in the face of parental objection.").

155. *Id.*; see also Nina A. Kohn, *Outliving Civil Rights*, 86 WASH. U. L. REV. 1053, 1065 (2009) ("[M]andatory reporting laws have been repeatedly critiqued on moral grounds.").

156. A. Kimberley Dayton, et al., *Advising the Elderly Client* § 4A:20 ("A person of sound mind who chooses to live in a state of self-neglect, for example, has the right to make that choice—her age should have nothing to do with whether she is stripped of her autonomy in small or large ways. The difficulty in all such cases is whether such a person's 'choice' is truly a free one, or rather the result of fear, lack of information, or other factors . . . . Ultimately, the professional charged with the duty to report or investigate must decide whether a particular elderly person has the 'right' to be exploited, abused, or neglected as matter of her own free will, or instead, if forces should be set in motion that might eventually deprive her of her sense of self, self-worth, and autonomy.") [hereinafter Dayton].

157. Benjamin Pomerance, *Finding the Middle Ground on A Slippery Slope: Balancing Autonomy and Protection in Mandatory Reporting of Elder Abuse*, 16 MARQ. BENEFITS & SOC. WELFARE L.R. 439, 485 (2015).

al, and it is often compounded by the fact that it may be difficult to determine whether an elderly victim does not want to report out of fear of retaliation.<sup>158</sup> Statutes that carefully define elder abuse and distinguish between abuse and self-neglect may help to encourage reporting on the part of health care professionals who wish to respect their patients' autonomy or maintain a healthy patient-physician relationship.

Many deride mandatory reporting as ageist, claiming that mandatory reporting statutes "selectively undermine the autonomy of older adults based on stereotypes about aging."<sup>159</sup> These critics see mandatory reporting as a significant imposition on the autonomy of elderly people, "especially where mandatory reporting laws apply to cognitively intact seniors."<sup>160</sup> This becomes especially problematic given the wide variance in definitions of elder abuse. Definitions of elder abuse vary widely from state to state.<sup>161</sup> In some states, elder abuse encompasses self-neglect. In the context of mandatory reporting, this would mean that doctors, nurses, and other mandated reporters could be forced to report elderly persons who may not be able to care for themselves as well as they previously could.<sup>162</sup> In many cases, this could lead to institutionalization of elders. However, many elderly people do not wish to be institutionalized. For the purposes of this note, elder abuse is assumed to refer to abuse perpetrated by others, e.g. not self-neglect.<sup>163</sup> It is of note, however, that "the inclusion of self-neglect in mandatory reporting schemes has been criticized as a form of 'social control' unduly limiting individuals' self determination."<sup>164</sup>

Ultimately, "these concerns pale in the face of serious underreporting and graphic examples of its consequences."<sup>165</sup> In fact, the American Medical Association itself supports mandatory reporting laws despite the fact that some facets of these laws can be problemat-

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158. Dayton, *supra* note 156.

159. Kohn, *supra* note 79, at 1066.

160. *Id.* at 1065-66.

161. Barber, *supra* note 11, at 111 ("Consistent definitions of elder abuse do not exist because each state has a different statutory definition.")

162. Kohn, *supra* note 79, at 1064.

163. For an interesting discussion on the intersection of the autonomy of elderly people, self-neglect and mandated reporting, *see generally* Faulkner, *supra* note 74.

164. Kohn, *supra* note 79, at 1064.

165. Velick, *supra* note 7, at 167-68.

ic.<sup>166</sup> Without mandatory reporting laws, there would likely be even more instances of unreported and undetected elder abuse. Critics of mandatory reporting should look for ways to adjust the current laws to more adequately address the needs of the elderly population. It is also crucial to work on enforcing mandatory reporting laws, because without enforcement, the laws cannot be fully effective in encouraging the detection and reporting of elder abuse.

#### IV. Recommendation

Mandated reporting should be standard across the states and should address the needs of the elderly population specifically. This means that it should be responsive to the needs of the elderly population and should both respect their rights and help provide a safe means of reducing underreporting of elder abuse.

The wide variety of standards in punishing failure to report elder abuse came about because of the lack of federal direction.<sup>167</sup> In order to adequately address the problem of underreporting elder abuse, there should be a consistent standard that is enforced and supported. While criminal prosecution for failure to report elder abuse clearly demonstrates that the problem is a serious one, if it is not enforced, then it cannot be actually effective in addressing and correcting the problem.

Under-enforcement of criminal penalties is not the only problem with criminal statutes. While individuals may be held criminally responsible, and can even face jail time, under statutes such as California's, this does not correct the widespread lack of education in the health profession regarding elder abuse and mandatory reporting of elder abuse.<sup>168</sup> In order to effectively combat elder abuse, mandatory reporting statutes should emphasize and encourage education and awareness of both the nature of elder abuse itself as well as the actual mandatory reporting statutes. Criminal statutes, which go largely unenforced against those very professionals who are critical to effective mandatory reporting, do not incentivize or encourage education or awareness of mandatory reporting and elder abuse.<sup>169</sup>

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166. *Id.* at 177 ("Perhaps the most significant aspect of the AMA's campaign is its strong support for mandatory reporting laws.").

167. Kohn, *supra* note 79, at 1058-59.

168. *Id.* at 1083-84.

169. *Id.*

In addition, if penalties for failure to report elder abuse are harsher than penalties for elder abuse itself, then society is sending a misleading message about the seriousness of certain crimes. While failure to report elder abuse is certainly a serious problem, especially given the largely isolated nature of the elderly population, it seems counter-intuitive to punish the failure to report more harshly than the actual abuse itself, which is the crime society is ultimately trying to eradicate.

In order for mandated reporting to succeed, the statutes need to be carried into effect. If prosecutors are unwilling to enforce criminal sanctions against doctors and other professionals, then the statutes targeting this issue carry no weight.

Likewise, if the burden of criminal prosecution cannot be sustained by the unique needs of the elderly population, then having criminal statutes does not provide an incentive to report. The criminal justice system operates slowly. Due to the health needs of the elderly, a lengthy court process that requires them to physically come to court to testify may not be feasible.

On the other hand, civil penalties, such as fines against institutions, would likely provide a hefty incentive for enacting procedures, training, and support for personnel who work in nursing homes or hospitals and may witness elder abuse or signs of elder abuse.

Finally, the standard used to punish failure to report elder abuse should be responsive to the needs of the elderly population. While it is extremely important to encourage the reporting of elder abuse, it is also important to balance that need with the need to respect the autonomy of elderly people. While some elderly persons may be incapacitated, many elderly people are quite capable of making their own decisions and their decision-making capacity should be respected. However, any system that is expected to adequately address the issue of elder abuse must also be responsive to the health needs of the elderly population. Criminal prosecution moves slowly. Elderly people may not be able to wait years for the end of the criminal prosecution. Furthermore, requiring elderly people to return to the courtroom many times over a long period of time may simply not be appropriate given their health and physical abilities.

A more effective approach to punishing failure to report elder abuse would be to impose civil remedies, such as fines, on both institutions and individuals responsible. Civil remedies would be more

effective because the civil legal process typically takes less time than the cumbersome criminal processes. This would increase the likelihood that elderly people who wanted to pursue charges against those who failed to report would actually be able to participate in the process and see the end result. In addition, imposing civil penalties would remove prosecutor's reluctance to impose criminal sanctions on white collar professionals, such as doctors and other hospital staff.

Imposing civil fines on institutions would incentivize the institutions themselves to monitor their staff and train their staff in proper procedures for reporting elder abuse. Proper training and enforcement of mandatory reporting statutes on both an institutional and civil level would greatly increase reporting of elder abuse.

## V. Conclusion

Because underreporting is one of biggest obstacles to combating elder abuse, it is critical that we have uniform laws that effectively incentivize mandated reporters to actually report elder abuse. While criminal penalties for mandated reporting provide some important incentives for those professionals who are in a position to help the vulnerable elder population, having statutes that are unenforced takes away from the effectiveness of the incentives. Additionally, the criminal justice system itself may not work well for the needs of the elder population. While it is important to demonstrate that elder abuse and the failure to report elder abuse is indeed a very serious problem, the criminal justice system is not structured in a way that is conducive to the needs of the elderly population. Because of the length of the trial, the high burden of proof, and the type of evidence that can be admitted in a criminal trial, it is quite possible that even if criminal statutes were enforced, they would not provide a very useful remedy for the victims.

Civil penalties are easier to enforce and can be levied against both individuals and institutions. Being able to levy penalties against institutions rather than just individuals is important because often the institutions have not enforced proper reporting procedures among their employees. Civil penalties against institutions could be especially effective in providing incentives for institutions to put procedures and training into effect for reporting elder abuse. This would effectively deter reporting failures as it would create a direct economic incentive for institutions to enforce mandatory reporting statutes. Civil

penalties against individuals would also create more incentive because they would alleviate the problem of prosecutorial reluctance to punish white-collar professionals. Proper reporting is critical to ensuring that elder abuse is properly prosecuted. Civil penalties for failure to report would be more effective at incentivizing both institutions and individuals to properly report elder abuse. Proper reporting of elder abuse is critical because it gives police and prosecutors the tools to enforce penalties against those who abuse elders.

In order to incentivize education and awareness of elder abuse and standards and procedures for mandatory reporting, as well as to provide an effective remedy for those victimized by elder abuse, it would be far more effective to have civil remedies for failure to report elder abuse. These civil remedies should be enforceable against both individuals and institutions, so as to properly address health professionals who work for large institutions and facilities and to provide a means of redress against individuals who fail to report.